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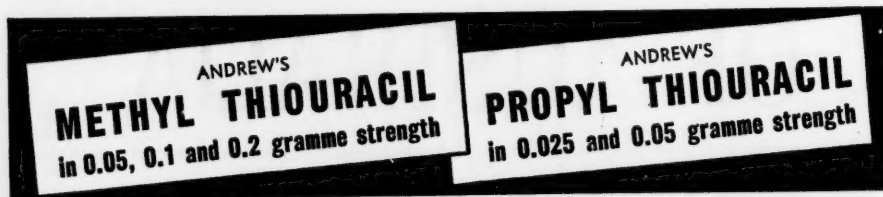
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THE RELATION BETWEEN THE NUTRITIONAL STATUS OF CHILDREN AND THEIR FOOD CONSUMPTION.

By PHYLLIS ASHWORTH,
Australian Institute of Anatomy, Canberra.

Introduction.

PÆDIATRICIANS and nutritionists interested in the relation of the nutritional status of children to the food pattern of the child will appreciate that malnutrition is not merely a matter of diet. Malnutrition may be, and often is, due to a defective diet, particularly one that lacks the "protective" foods. But it would be misleading to approach the problem thinking only of food. In its widest sense the nutritional state of the child may be adversely affected by such factors as poor housing and poor conditions generally, undue fatigue produced by lack of proper sleep, long, tiring journeys to and from school, as well as long intervals between meals and excessive home duties. Economic circumstances are obviously important, and though malnutrition may be the result of poverty, the self-contained economy of many rural dwellers leads one to the conclusion that families can be well fed though extremely poor. On the other hand, households which do not suffer from poverty of purchasing power often live at an unnecessarily low nutritional standard, due to poverty of knowledge.

Recently an opportunity occurred to study the nutritional status of children and their food consumption in relation to the general food pattern of the households of which they were members. The numerous food consumption surveys made in various parts of the world during the last decade emphasize the need and importance of this type of investigation.

The site chosen for this study was the Adelaide Hills district of South Australia. For the past seven years the Adelaide Hills Children's Health Survey has been in operation. By this means a check has been kept on the health, physical development, including physical defects and nutritional status of the children living in the area. The results of the activities of the survey have been published by Jungfer.⁽¹⁾

This district has a comparatively dense and stable population which is grouped into a number of somewhat self-contained communities. The inhabitants are engaged in dairy and sheep farming, in fruit and vegetable growing and in the wool and textile industry.

The present investigation covered 100 households comprising 510 individuals. The nutritional status of 284 children was studied in relation to the food consumption and dietary levels of their homes, and the individual food consumption and dietary level of each child was correlated with the child's nutritional status.

Selection of Households.

Length of Residence of Family in the District.

The Hills area has been settled for approximately a century. The families selected had lived for at least twenty years in the district. Many had in fact lived for three generations in the same house, so that a stable population was surveyed, well adapted to the food supplies available in the area.

Number of Children in the Household.

An attempt was made to include as many children as possible in the 100 households, and those with large families were visited in preference to those with only one child. However, ten households with one child were included, providing more random sampling.

Localities Surveyed.

This investigation was limited to Lobethal and the two nearby districts of Forest and Charleston. The Lobethal district contains two distinct communities.

One group includes the descendants of a group of German refugees who settled there in 1842 and acquired land at £1 an acre from the Government. They established their own Lutheran Church and to this day maintain a fairly separate community. Their occupation is basically that of peasant farmers, with food customs largely a survival of a self-contained economy. This community is referred to in this report as the Lobethal Lutheran district.

In 1872 establishment of the Onkaparinga Woollen Mills at Lobethal led to a second influx of settlers, this time of British stock, mainly from the textile works of northern England. Their descendants are still mainly mill employees, dwelling in the township of Lobethal.

Fruit and vegetables are brought to the town from the Adelaide market, 25 miles away. Meat is supplied from the local abattoir. A door-to-door delivery of milk is made by one dairyman, although a few of the townsfolk keep their own cows. The soil is amazingly fertile, and most of the inhabitants grow potatoes and other vegetables. Fowls are frequently kept.

The Charleston district is mainly agricultural and "mixed" farming predominates. There is a general store in the town. Bread and meat are delivered three times a week and a fruit and vegetable van delivers produce from the Adelaide market to the householders once weekly. There is no delivery of milk, but most of the inhabitants have a cow and grow potatoes and other vegetables.

Forest was originally heavily wooded range country and timber cutting became a preliminary to agriculture. The fertile cleared valleys were gradually cultivated for vegetables. Today these ranges are inhabited by gardeners who supply fruit and vegetables in abundance to the Adelaide market. They are self-supporting as regards all types of vegetables, as well as soft, berry and pome fruits, but little citrus fruit is grown. There are no shops in this district and no milk delivery. Bread and meat are delivered as at Charleston. Families without a cow obtain their milk from those neighbours who have a cow and a superfluity of milk.

Procedure Adopted to Obtain Data in this Survey.

The dietary survey was made by the *questionnaire* method⁽²⁾ modified to suit the area. The forms used contained additional details concerning housing conditions and medico-social problems, and a separate form was used for each child. On this form were listed hours of rest and time spent away from home each day, home duties, home atmosphere and individual food idiosyncrasies.

In the evaluation of each household diet the following details were compiled: (a) the composition of the household; (b) the daily household consumption in ounces of milk, cheese, potatoes, bread, and the number of eggs; and (c) an estimate of the number of times daily the following were served: breakfast cereals, whole-grain or otherwise, meat, bacon, vegetables, tomatoes, citrus and other fruit. If any member of the family did not eat any particular food, a note of this was made, with consequent adjustment when intake was assessed.

It was found that the best results were obtained if the housewife was not confronted with a sheaf of papers containing questions. An informal attitude was adopted, and an attempt was always made to hold the interview without display of pencil and paper, in the kitchen. Much valuable information was collected concerning the commissariat and management of food problems in general by observation alone. The interview took place soon after breakfast or the midday meal, when the housewife was normally engaged in the kitchen, and the remains of the usual meal pattern were evident. No preliminary propaganda concerning the survey had taken place, and the visit was generally quite unexpected. The housewife was informed that visits were being paid to the district in connexion with child health and was asked if any of her children presented any problems of health, behaviour or food habits. From this beginning there was no difficulty in obtaining all the information required. It should be appreciated that many of the housewives had limited contact with community life. Their horizon was small and near and largely that bounded by the farm, the home and the family, and they usually welcomed any interest from outside these.

Evaluation of Specific Nutrients and Statistical Treatment of Data for Households.

Evaluation of Specific Nutrients.

The intake of specific nutrients was calculated for each household and these values were compared with standards derived from the table drawn up by the National Research Council.⁽³⁾ In accordance with the procedure adopted in the report of the Combined Food Board on Food Consumption Levels in Australia and the United Kingdom,

October, 1944,⁽⁴⁾ average (restricted) recommended allowances for specific nutrients were used. Every household was graded for each nutrient into one of three categories, as follows: (i) satisfactory: fulfilling the National Research Council (restricted) recommended allowances (revised, 1945); (ii) unsatisfactory: falling to meet the National Research Council (restricted) revised recommended allowances by a margin of greater than 10%; (iii) borderline: falling between these two categories.

The intake of protein, thiamine, ascorbic acid, calcium and Calories was assessed for each household. Of these nutrient factors the intake of calcium and Calories was calculated on the household basis, since accurate weights of the weekly consumption of milk, cheese, butter, eggs, bread, potatoes and sugar were available.

In the assessment of the intake of protein, thiamine and ascorbic acid, however, certain modifications had to be introduced. The daily consumption of such foodstuffs as breakfast cereals, meat, vegetables and fruit had been recorded in terms of servings. The size of a serving is not the same irrespective of the age group of the recipient. Its size is based, on broad lines, on caloric intake, since the requirements of women and children are, in general, less than those of an adult man. In large-scale public health work it is usually necessary to employ some scale of family coefficients. The conversion factor adopted here is that recommended by the Health Organisation of the League of Nations.⁽⁵⁾ It is now generally used for the purpose and is as shown in Table I.

TABLE I.

Age. (Years.)	Coefficient.		
	Male.	Both Sexes.	Female.
0 to 2	—	0.2	—
2 to 3	—	0.3	—
4 to 5	—	0.4	—
6 to 7	—	0.5	—
8 to 9	—	0.6	—
10 to 11	—	0.7	—
12 to 13	—	0.8	—
14 to 59	1.0	—	0.8
Over 60	—	0.8	—

Thus in the estimation of the household intake of protein from meat served once a day, in a family consisting of husband, wife and two-year-old child, the conversion coefficient would be 2.0. One adult male serving of meat (four ounces of edible portion) is equivalent to 20 grammes of protein. The family protein intake from meat is therefore 40 grammes per day. Similar assessments were made for thiamine and ascorbic acid.

Iron.—For a number of reasons iron was not assessed. The amount of iron present in any particular foodstuff is less important than the availability of that iron. To be biologically available it must be in a form that is soluble, ionizable and ultrafiltrable. Absorption of iron from the intestinal tract is probably dependent on the level of iron in the blood serum of the individual.⁽⁶⁾ It would therefore be inaccurate to assess iron by a dietary appraisal alone.

Vitamin A.—Vitamin A was not assessed. The National Research Council's recommended allowances for vitamin A of 5000 international units per adult male per day and related amounts for different sex and age groups were proposed on the best evidence available in 1941. Since this time experimental evidence has been produced which indicates that these recommended allowances for vitamin A are too high.⁽⁷⁾ Many factors complicate the conversion of the precursor carotene to vitamin A in man.^(8,9) It is possible to estimate the intake of vitamin A and carotene from the information on the *questionnaire* form, but in the absence of accurate standards of adequacy for vitamin A the assessment would be without value.

Protein.—The 1944 Australian Food Consumption Survey⁽¹⁰⁾ showed that 91% of the protein in the average Australian diet is provided by meat, eggs, cheese, vege-

tables, potatoes, fruit, breakfast cereals and bread. The daily intake of protein from these foods was calculated from the daily household consumption of milk, cheese, eggs, potatoes and bread, and the estimated number of daily servings of the other foodstuffs, expressed as adult male units. In the assessment of all nutrients, edible portions of foodstuffs were taken. The values shown in Table II were used.

TABLE II.

Food.	Quantity.	Protein. (Grammes.)
Breakfast cereal ..	1 serving.	2
Milk	1 oz.	1
Cheese	1 oz.	6
Eggs	Each.	6
Bread	1 oz.	2
Potato	2½ oz.	1
Other vegetables ..	1 serving (3 oz.).	2
Meat	1 serving (4 oz.).	20

Households were graded as follows:

Intake of protein 91% or more of household requirement = satisfactory.

Intake of protein 82% or less of household requirement = unsatisfactory.

Intake of protein 83% to 90% of household requirement = borderline.

Thiamine.—The 1944 Australian Food Consumption Survey showed that 84% of the thiamine in the average Australian diet was provided by milk, eggs, bacon, meat, whole-grain products, bread, potatoes and other vegetables. Calculation was made for each household from the daily household consumption of milk, eggs, bread and potatoes, and the estimated number of servings of the other foods, the key shown in Table III being used.

TABLE III.

Food.	Quantity.	Thiamine (γ)
Milk	1 oz.	10
Eggs	Each.	100
Wholegrain bread ..	1 oz.	66
White bread	1 oz.	30
Potatoes	1 oz.	25
Other vegetables ..	1 serving (3 oz.).	65
Meat	1 serving (4 oz.).	65
Bacon	1 serving (1 oz.).	200
Wholegrain breakfast cereal	1 serving.	130

Households were graded as follows:

Intake of thiamine 84% or more of household requirement = satisfactory.

Intake of thiamine 75% or less of household requirement = unsatisfactory.

Intake of thiamine 76% to 83% of household requirement = borderline.

Ascorbic Acid.—Ascorbic acid was calculated from the consumption of citrus fruit, tomatoes, other raw fruit, raw and cooked green vegetables and potatoes. It is almost impossible to assess with precision the contribution of ascorbic acid provided by vegetables that are neither fresh nor cooked by conservative methods, and in this respect survey data give a comparative rather than an absolute value. Fresh cooked greens may provide considerable amounts of the vitamin. Although 60% to 100% of the vegetables used in the Hills households were home-grown and reasonably fresh when consumed, it has been deemed advisable to accord them with a low value for ascorbic acid, a wide margin being allowed for cooking losses. The contribution of ascorbic acid made by old potatoes is small, while that of new potatoes is high, especially in the diet of the adult. According to Honey⁽¹⁾ the ascorbic acid content of foodstuffs considered in this questionnaire comprised 92% of the total ascorbic acid intake of an average

South Australian population. Calculation of household grading was made from the daily consumption of potatoes in ounces, and the estimated number of adult male-size servings of the other foods, the key shown in Table IV being used.

TABLE IV.

Food.	Quantity.	Ascorbic Acid. (Milli- grammes.)
Citrus fruit	1 serving.	35
Tomatoes	1 serving.	15
Other raw fruit ..	1 serving.	10
Raw green vegetables ¹ ..	1 serving.	10
Cooked green vegetables ² ..	1 serving.	15
Potatoes	1 oz.	2.5

¹ Mainly lettuce.

² All vegetables in season, excluding potatoes and other root vegetables.

Households were graded as follows:

Intake of ascorbic acid 92% or more of the household requirement = satisfactory.

Intake of ascorbic acid 83% or less of the household requirement = unsatisfactory.

Intake of ascorbic acid 84% to 91% of the household requirement = borderline.

Calcium.—The 1944 Australian Food Consumption Survey showed that 75% of the calcium in the average Australian diet is provided by milk and cheese. The calcium contributed by the consumption of these foodstuffs was calculated for each household, the key shown in Table V being used.

TABLE V.

Food.	Quantity.	Calcium. (Milli- grammes.)
Milk	1 oz.	33
Cheese	1 oz.	220

Households were graded as follows:

Intake of calcium 75% or more of household requirement = satisfactory.

Intake of calcium 67% or less of household requirement = unsatisfactory.

Intake of calcium 68% to 74% of household requirement = borderline.

Calories.—The 1944 survey showed that 60% of the caloric intake in the average Australian diet was provided by bread, potatoes, milk, butter, cheese, eggs and sugar. Calories contributed by the consumption of these foods were calculated for each household, the key shown in Table VI being used.

TABLE VI.

Food.	Quantity.	Caloric Value.
Bread	1 oz.	70
Sugar	1 oz.	110
Potatoes	1 oz.	20
Eggs	Each.	80
Cheese	1 oz.	120
Milk	1 oz.	20
Butter	1 oz.	200

Households were graded as follows:

Intake of Calories 60% or more of household requirements = satisfactory.

Intake of Calories 54% or less of household requirements = unsatisfactory.

Intake of Calories 55% to 59% of household requirements = borderline.

TABLE VII.
Number of Households in Each District and Grading of Specific Nutrients.

District.	Calories.			Protein.			Thiamine.			Calcium.			Ascorbic Acid.		
	S. ¹	UnS. ¹	B. ¹	S.	UnS.	B.	S.	UnS.	B.	S.	UnS.	B.	S.	UnS.	B.
Lobethal	18	2	5	24	1	—	21	—	4	12	7	6	18	5	2
Lobethal Lutheran	22	2	1	25	—	—	23	1	1	12	9	4	18	4	3
Charleston	21	2	2	23	—	2	23	—	2	17	7	1	21	4	—
Forest	21	—	4	25	—	—	23	1	1	17	7	1	18	3	4
Percentages	82	6	12	97	1	2	90	2	8	58	30	12	75	16	9

¹ S. = satisfactory. UnS. = unsatisfactory. B. = borderline.

Statistical Treatment of Data.

From the evaluation of the specific nutrients and the grading of households for each, the numbers and percentages of households which had a satisfactory or unsatisfactory level of protein, thiamine, calories, calcium and ascorbic acid intake are given in Table VII.

Calories.—It will be seen that 18% of households had a caloric intake below the National Research Council recommended allowance. Since these allowances are based on the average desirable intake of moderately active adults, it is easily seen that individuals could have a lower caloric intake and still obtain enough to meet their requirements. With a few exceptions, to be referred to later, there was no evidence of starvation ("undercaloried nutriture") in the households surveyed.

Protein.—In three households the protein intake was suspect, in one it was unsatisfactory and in two it was borderline. Thus the level of protein intake in these households was similar to that reported in other Australian surveys, there being little or no evidence of inadequate protein intake.

Thiamine.—In the average Australian diet thiamine is provided in almost equal amounts by the four main food groups—cereals, meat, dairy products and fruit and vegetables. The 1944 Australian Food Consumption Survey showed that from 20% to 66% of households failed to meet the recommended allowance. In the Adelaide Hills district 90% of households were satisfactory.

Ascorbic Acid.—According to the 1944 Australian Food Consumption Survey ascorbic acid appeared to be consumed in excess of the recommended allowance, but cooking losses and length of storage of foodstuffs were not taken into account. These survey data are therefore relative. In the Hills survey, however, the net intake of ascorbic acid from foods which were considered to be reliable sources of the vitamin was calculated on the basis already discussed; 75% of households have a satisfactory intake. It will be noted that Forest (the "kitchen garden of Adelaide", where almost every household is abundantly supplied with fruit—not citrus—and vegetables) has a grading for ascorbic acid which varies only slightly from those districts having little local supply of fruit. This emphasizes the importance of potatoes and vegetables in providing the bulk of the dietary ascorbic acid intake. With the exception of the citrus variety, fruit makes a comparatively small contribution in South Australia. Reference to the figures given by Honey⁽¹¹⁾ shows that 10% of the ascorbic acid intake is provided by fruit on a per-capita annual basis.

Calcium.—Survey data to date have revealed that in Australia a high proportion of households fail to meet the recommended allowance for calcium. This is supported by the findings in the Adelaide Hills area, where 30% of households were classified as unsatisfactory. It will be noted that in both the Forest and Charleston districts 68% of houses had a satisfactory calcium intake. In Charleston, although 56% of the houses surveyed were dairy farms, it did not follow that milk was drunk in abundance. Dairy farmers and their families on an average drink less milk than other individuals and the calcium picture is often one of poverty in the midst of plenty. In Forest, as stated earlier, milk is not delivered, but is supplied to households through the goodwill of neighbours. At Forest school, however, each child may obtain for one penny a six-ounce

glass of milk at midday. No allowance was made for this in the household survey, but allowance for this additional milk was given in assessing the nutrient intake of each individual child later.

A higher percentage of households in Charleston and Forest were found to have a satisfactory intake of calcium than in Lobethal and among the Lobethal Lutherans, although 56% of the latter were dairy farmers. It will be noted that in the Lobethal districts only 48% of households had a satisfactory calcium intake, but the percentage is undoubtedly a great deal higher. There are five milk bars in the township, and milkshakes and ice-creams are consumed in large quantities, especially by the school children at lunch time and after school.

Food Patterns of Individual Children in Relation to that of the Household.

The food pattern of each child was studied in an endeavour to ascertain whether for any reason it differed from that of the household. Of the 284 children studied, the food pattern of 49 was different from that of the household. In the case of 13 it was inferior and for 36 superior to the grading of the household. Superior diets resulted from special consideration being given to the child. Where fruit and oranges were bought in limited quantities, these were reserved for the children. Likewise, in milk-conscious households the children were given the bulk of the milk purchased. In every case the reason for the differentiation in favour of the child was economic. Once the child's needs were met, the housewife either would not, or could not, spend more on food. Analysis of the reasons causing inferior diets for 13 children showed that this was due to food faddism of the child (eight cases), maternal eccentricity (three cases) and financial stress (two cases). For some children alteration occurred in the grading of more than one nutrient (Table VIII).

TABLE VIII.
Children with Diets not Conforming to Household Pattern.

Grading of Diet.	Nutrients Affected.				
	Protein.	Thiamine.	Calories.	Calcium.	Ascorbic Acid.
Superior (36) ..	—	—	6	19	17
Inferior (13) ..	4	4	2	6	2

Physical Appraisal and Nutritional Status of Children.

Dr. C. C. Jungfer has studied the physical growth, health and nutritional status of the children in the Lobethal area for many years and a comprehensive report has been published.⁽¹²⁾ For this investigation Dr. Jungfer supplied an assessment of the physical growth, health and nutritional status (determined by clinical methods) for the children of each household surveyed. This information has been treated statistically and the χ -squared test applied. It was found that there was no correlation between the nutritional state of the child and the presence of physical defects, such as diseased tonsils, caries, defective vision ($P < 0.1$).

TABLE IX.
Nutritional Status of Children in Relation to Dietary Pattern of the Household.

Nutritional Status of Children.				Household Grading for Nutrients.														
				Protein.			Thiamine.			Calories.			Calcium.			Ascorbic Acid.		
				S. ¹	UnS. ¹	B. ¹	S.	UnS.	B.	S.	UnS.	B.	S.	UnS.	B.	S.	UnS.	B.
Lobethal—																		
Satisfactory				35	—	—	32	—	3	31	1	3	23	6	6	27	4	4
Unsatisfactory	56	..	..	20	1	—	19	—	2	14	3	4	6	11	4	12	9	—
Lobethal Lutheran—																		
Satisfactory				65	—	—	58	—	7	59	6	—	31	22	12	49	8	8
Unsatisfactory	74	..	..	9	—	—	7	—	2	7	—	2	5	4	—	5	2	2
Charleston—																		
Satisfactory				48	—	6	51	—	3	46	3	5	38	15	2	46	8	—
Unsatisfactory	62	..	..	8	—	—	8	—	—	7	1	—	6	1	—	5	3	—
Forest—																		
Satisfactory				73	—	—	69	1	3	59	—	14	45	26	2	55	2	16
Unsatisfactory	92	..	..	19	—	—	17	2	—	18	—	1	14	4	1	13	4	2

¹ S. = satisfactory. UnS. = unsatisfactory. B. = borderline.

Nutritional Status of Children and Dietary Pattern of Household.

Children were divided into two groups, those with a satisfactory and those with an unsatisfactory assessment of nutritional status, as provided by Jungfer. This was tabulated against the household food pattern, presented in Table IX.

Statistical examination of these figures revealed that there is no correlation between the nutritional status of the child and the household dietary pattern, with the possible exception of calcium intake in the Lobethal township. Here there is a suggestion that unsatisfactory calcium intake is associated with unsatisfactory nutritional status ($P < 0.01$). In the three other districts, however, a high percentage of households with children whose nutritional status was satisfactory did not reach the desired level of calcium intake. In view of this observation it is difficult to place any scientific interpretation on the Lobethal results.

The next step was to examine the food pattern and home background of every child with unsatisfactory nutritional status. The study was intensive rather than extensive, history in retrospect being the aim, at the psychosomatic level. Brief notes concerning the findings for each child are appended.

A1. M8. This child had been adopted when one year old by a childless couple, married twelve years previously. The foster mother was temperamental and eccentric. The child had an economically sound background, but was given great freedom of action, especially regarding food. His meals lacked supervision and planning; frequently he had only biscuits for breakfast.

A2. M13. For many years had shown a dislike of meat, cheese and vegetables, but was said to be improving.

A3. F3. Had lived for twelve months on German sausage, fruit and four glasses of milk per day.

A4. F9 and M9. No idiosyncrasies were detected. These children were unidentical twins, with no other children in the family. No apparent explanation was found.

A11. F8. Was born prematurely at seven months, being delivered by Caesarean section. Nothing else significant was found.

A12. F14. For some years had bought her lunch at a tuckshop; had no satisfactory meal during the week. The family had hot midday dinner. The evening meal, shared by F14, consisted of pancakes, or fried potato chips, bread, butter and jam. Except for the contents of the pies and pasties bought for lunch, meat and vegetables were absent from the diet of F14 during the school week. The household used very little milk and practically no fresh fruit.

A15. F14. For some years had suffered from bronchiectasis, chronic sinusitis and hysteria. The mother appeared unstable and the child an exhibitionist.

A16. F9. Refused to eat eggs, oranges or tomatoes.

A17. F9. For many years had been a poor eater and had to be coaxed through each meal. She was the youngest in the family by eight years and was always treated as the "baby".

A22. M18, F15, M12, F5. Two factors operated in this household: inadequate food and rest. The dietary background was poor; catering was chaotic. Two pints of milk were shared between six people. The four children slept in one room, containing two beds.

A24. F18, M11. No significant facts were obtained.

A25. M13, F11. Had endured very casual catering by a mother more interested in farming than in food and home. She considered that one egg once a week between the two children was ample. Hundreds of eggs were sold each week.

B1. M15. No significant facts were obtained.

B8. F9. Had existed under a very poor dietary régime, due to eccentricity of the mother. She was allowed very little meat and no cheese. The mother helped with milking and timber cutting, the child becoming a household drudge as a result. She prepared her own breakfast and cut lunch, walked three miles to school, and frequently walked home again.

B15. F9. No significant facts were obtained.

B17. F14. No significant facts were obtained.

B17. F12. A difficult child concerning food, seldom following the normal household food pattern.

B18. M2. Had consistently refused to eat any vegetables since starting a mixed diet.

B22. F13 and M8. Both suffered from hay fever, were allergic to porridge and "Granose" and disliked all vegetables.

B25. F8. For some years had lived almost wholly on milk, cod liver oil emulsion and fruit; had always exhibited pronounced food faddism and has chronic bronchitis. She was the youngest in the family by ten years.

C2. M9. No significant facts were obtained.

C5. M3. Had never been cooperative regarding food. A psychological approach was always necessary, for example, he would eat an egg only if he gathered it himself and had it specially marked before being cooked.

C6. M11. Would not eat meat.

C13. M4. The household dietary background was poor, the living conditions were unsatisfactory, and the child had always refused to eat eggs. His only beverage was tea with a "dash" of milk in it.

C15. F15. Had had alopecia for many years and a poor appetite.

C16. F11 and M4. Lived in an unsatisfactory home atmosphere and shared a bed at night.

C18. M8. Suffered from chorea.

D4. M14. Had an inadequate breakfast and a sandwich lunch, and was away from home for eleven hours on schooldays, travelling to the city (25 miles) and back.

TABLE X.
Factors Underlying Unsatisfactory Nutrition.
(54 Children.)

Factors Suggesting Unsatisfactory Nutrition.	Classification.	Lobethal.	Lobethal Lutheran.	Charleston.	Forest.
Maternal antagonism	Psychogenic.	—	—	—	1
Maternal neurosis	Psychogenic.	—	—	—	1
Maternal disinterest	Psychogenic.	3	—	—	—
Maternal eccentricity	Psychogenic.	1	1	—	(2)*
Food faddism of child	Psychogenic.	3	3 (2)*	2	—
Exhibitionism of child	Psychogenic.	2	—	—	1
Individualism of child	Psychogenic.	—	—	—	2
Allergic disease	Allergy.	—	2*	—	—
Inadequate rest, unsatisfactory home environment and inadequate diet	Deficiency.	4†	—	2	—
Immaturity at birth	Prematurity.	1	—	2	2
Twins	Prematurity.	1 pair	—	—	1
Economic	Financial.	—	—	—	2†
Disease, mental or physical	Frank disease.	—	—	1	2
Undiscovered reason		2	3	1	7
Total		18	9	8	19

* Four children in one family suffered from inadequacies of both rest and diet.

† Two in one family were the victims of economic stress plus maternal eccentricity.

* With two children allergic disease resulted in food faddism

In the last two groups, economic stress and allergy were considered the basis of the condition.

D5. M10, F5 and M2. No significant facts were obtained.

D8. F4. Mentally and physically retarded and lacked coordination of movement.

D9. F3. Lived under a poor dietary régime with inadequate intake of butter and milk and no cheese.

D11. F5. An asthmatic.

D12. F12. Had bronchiectasis and oxyuriasis (frank disease).

D15. F5 and F2. Had an unsatisfactory background. The mother was neurotic and stated that there was great antagonism between herself and the older child. Both children had poor appetites.

D16. F14 and M10. Had endured a poor dietary régime, caused by a combination of economic stress and maternal eccentricity.

D17. F8. Was found to exhibit pronounced individualism. She had no really bad food habits, but her behaviour, play and interests were entirely different from those of the rest of the family. She was the second of five children.

D18. F14. No significant facts were obtained.

D19. F5. Had always been undersized; was five pounds in weight at birth. Nothing else significant was found.

D20. M11. No significant facts were obtained.

D22. F8. At the age of two months developed infantile eczema and had suffered from retarded physical development since then.

D24. M9. No significant facts were obtained.

D25. F3. No significant facts were obtained.

In Table X the factors associated with the unsatisfactory status of these 54 children have been summarized.

These factors have been grouped under the following headings: psychogenic basis, 18; allergic disease, 4; inadequacies of rest and/or diet, 11; prematurity, 4; frank disease, physical or mental, 2; economic basis, 2; undiscovered basis, 13.

The largest group of children with unsatisfactory nutrition is that in which the nutritional status is directly related to a psychogenic basis. No underlying factor could be found in 13 cases. For only seven children was the causal factor for unsatisfactory nutrition an inadequate diet.

By comparison, analysis of information obtained concerning the remaining 230 children whose nutritional status was satisfactory revealed that four of these had a mild degree of food faddism, one suffered from exhibitionism and the remainder were normal. Thus there was a psychogenic factor operating in five cases and no relevant facts were obtained in 225 cases.

Summary.

1. A dietary survey was made of 100 households in the Adelaide Hills.

2. Of these households, 97% had an adequate intake of protein, 90% for thiamine, 83% for Calories, 58% for calcium and 75% for ascorbic acid.

3. Of the 284 children in the 100 households, 49 had a dietary pattern dissimilar to that of the household. In 13 instances it was inferior and in 36 it was superior.

4. Fifty-four children had unsatisfactory nutrition as determined by clinical methods by Dr. C. C. Jungfer. The nutritional status of these children bore no relation to the household dietary pattern. For seven children the unsatisfactory nutritional status was due to an inadequate diet.

5. Amongst the 54 children whose nutritional status was unsatisfactory it is possible that for 18 the basis was psychogenic. In contrast, amongst 230 children whose nutritional status was satisfactory there were five who might be placed in this category.

6. For 13 children no basis was discovered which might have accounted for the unsatisfactory nutrition.

7. For the remaining 16 children a number of factors were noted in the history of each child which might have played a part in the development of the unsatisfactory nutritional status.

8. This study showed that the food consumption pattern of the children of a household might not necessarily be the same as that of the household.

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MEDICAL SEQUELÆ OF BRAIN INJURY: A CLINICO-PATHOLOGICAL STUDY.¹

By LEONARD B. COX,
Melbourne.

In a section where neurology and psychiatry are joined it is more or less incumbent on a president to choose for his address a subject of mutual interest. According to one's approach that may be chosen in which the psyche is modified by organic disease, or that in which disturbance fundamentally of the mind modifies body activity. Being a neurologist I have naturally chosen the first course, for mechanism is the special function of our discipline.

I trust, therefore, that you will bear with me if I commence at the organic basis of disease, pathology or morbid anatomy.

Intracranial trauma is a fruitful realm for our groups to forgather in, and I will in particular deal with its late effects; but before doing so I will pay some attention to the immediate injury. We can then consider its repair and the final defect as well as such phenomena as arise from its scarring and vascularization.

Injury applied to the head region produces its effects in by no means as simple a way as might at first appear. The force of the injury, its direction, its position and the area to which it is applied are important factors. But there are others of significance, such as whether the head remains fixed despite the blow, or is suddenly moved, or conversely stopped in its movement by the impact.

Where a head is relatively immovable, as when a heavy object falls on that of a lying person, surprisingly little injury need occur, for the skull is a powerful structure and can take up a good deal of force without fracture. But even so, intracranial volume may be increased or decreased, according to whether the blow is sustained in an antero-posterior or lateral direction. Some force, therefore, can be transmitted to the intracranial contents and an effect produced even if the skull is not fractured, penetrated or crushed.

Where, however, the blow produces sudden, violent movement of the head, or when the head already in motion is suddenly decelerated, as in a fall or in a car accident, there may be serious injury to the brain. Now not only may the skull be fractured and the brain subjected to such forces as is the fixed skull, but also there is the possibility of a shearing movement of the brain within the cranial cavity. As the inner surface of the skull is by no means smooth, its bony ridges can lacerate the surface of the brain. Marked cortical laceration and hæmorrhage, particularly at the poles, is frequent.

Another feature of possible importance is the angulation which readily occurs at the atlanto-occipital junction. Whether this is the reason or not, considerable damage can take place at the very vital area underlying it, the brain stem.

Now let us consider various types of injury. These can conveniently be considered under three headings, although all types frequently exist together in different proportions. They are: (i) injuries of the deeper structures of the hemispheres, (ii) injuries of the cortex, and (iii) injuries of the brain stem.

Injuries of the Deeper Structures of the Hemispheres.

In force transmitted to deeper structures the shearing movement of skull on soft brain plays little part. A wave set up at the point of impact is transmitted throughout the brain. Its effect is destructive if it is severe. It may destroy nerve cells, fracture axones, separate and injure the endyma, and rupture and paralyse blood vessels so that hæmorrhage and œdema take place. Such hæmorrhages may be well seen in the white matter of the brain in certain cases of severe head injury.

At an early stage, as in all contused tissues, œdema arises about the contused areas; and where the contusion

is extensive the œdema is so too. Nevertheless, according to Greenfield, œdema is usually fairly circumscribed and largely confined to the contused or hæmorrhagic zones.

It shows, however, a predilection for the white matter of the *centrum ovale*, usually sparing the subarcuate fibres of the cortical zone and such long association tracts as the *corpus callosum* and the optic radiation. It is an important condition, and to its persistence some years ago the late Wilfred Trotter attributed, probably incorrectly, many of the features of the post-traumatic state.

The late effects of such lesions are our main concern today, that is, the stage of repair and its consequences. Brain scarring is derived from two main sources: blood vessels and their related connective tissue, and that special supportive tissue of the central nervous system, classical neuroglia. There is accordingly formation of new vessels with fibrosis and gliosis.

This vascularization of a contused or lacerated area may take place at a surprising rate. Connective tissue too rapidly forms, although gliosis is slower. The result is a considerable amount of contracting scar tissue which, when replacing destroyed neural tissue, will cause distortion of adjacent structures. But as well, after severe injury, there is often in particular a surprising loss of substance in the zone of the white matter, which seems too great to derive from contracting scar tissue alone, and in large sections of such brains a conspicuous loss of myelin has been observed. It is indeed likely that much of this myelin loss has followed œdema. This loss of white matter can be observed in the following cases.

CASE I.—A man, aged sixty-eight years, of moderate intelligence had had a severe head injury six years before; three years after the injury he developed epilepsy, each episode of which was followed by a severe psychosis. Seven years after my examination he died of heart failure. Examination of brain then showed widening of the ventricles in section closely conforming to the appearances in the encephalogram taken several years before.

The point that I wish to make is that, although grey matter may be relatively unaffected, there can be much loss of white matter with widening of ventricles and rounding of their angles. This loss of white substance is at times extreme, yet curiously enough a considerable amount of useful intelligence may be retained; and I should like to instance to you several such cases in which lesions were revealed by encephalography, in a scale descending from one with little intellectual impairment to one with a great deal.

CASE II.—B.W., a man, aged thirty-six years, had had a long period of unconsciousness after an accident thirteen years before; four years after the accident he had developed *petit mal* with automatism. He is today a fairly able man engaged in responsible testing work in the Aircraft Corporation. His encephalograms, however, show considerable dilatation of the ventricles.

CASE III.—L.R., a man, aged thirty-six years, was unconscious for five weeks after a motor-car accident fourteen years before; epilepsy developed after eleven years and later headaches. His mental capacity, although not as good as that of the previous man, was fair, and he could be usefully employed. Encephalography showed marked dilatation of both lateral ventricles.

CASE IV.—L.A., a woman, aged forty-five years, who suffered from both headache and epilepsy for which she had at one time had exploration, had sustained a blow on the head with a bottle many years before. X-ray examination showed very large ventricles and a varicosity of one presumably resulting from the distorting effect of a cortical scar. Her intelligence was moderate.

CASE V.—E.B., a woman, aged thirty-two years, had sustained a severe blow on the head from a mental patient whom she was nursing in an asylum, after which she was amnesic for five weeks. Afterwards she developed mild dementia with epilepsy. Nevertheless she was able to be retained in a sheltered occupation. Encephalography showed enlarged ventricles, but also some air over the cortex suggesting as well cortical damage.

CASE VI.—F.K., a man, aged thirty-seven years, had suffered a fractured base of the skull and been unconscious for two weeks after an accident. He became simple, obstinate and so difficult as to be unemployable. He also suffered from epilepsy. Encephalography showed dilated ventricles,

¹ President's address, delivered before the Section of Neurology and Psychiatry, Australasian Medical Congress (British Medical Association), Sixth Session, Perth, August, 1948.

one with a varicose appearance suggesting the contraction of a cortical scar.

CASE VII.—C.P., a man, had been unconscious for two weeks after an accident. Afterwards his behaviour was anti-social, and he was in and out of gaol for various crimes. He also suffered from epilepsy. Encephalography showed enormous dilatation of the ventricles.

From these examples you will observe the amount of brain damage which can result from brain injury, and may be surprised that effective individuals can yet emerge with such severe loss of substance. As in prefrontal leucotomy, it will be seen that the brain can yet function, and indeed that there may be little or no defect in pure intelligence, just as after this severe operation.

Injuries of the Cortex.

We will now consider cases in which the cortical damage appears greater than that of white substance and deep structures.

In some of the cases just described encephalography has shown evidence of cortical involvement as well as of involvement of white matter. But in others cortical damage has seemed great, while in deeper parts no significant atrophy was found. Perhaps this has been due to a greater shearing effect at the time of the accident of the type we have already briefly mentioned. But as well, from this vascular damage can eventuate, for the cortex is supplied from the surface by small perforating vessels which do not extend greatly beyond the grey matter. These when interrupted would cause cortical atrophy in their areas of supply. Here is a case associated with marked cortical atrophy.

CASE VIII.—C.O., a man, aged forty-two years, had suffered a car accident three years before, after which he was unconscious for five days. While in hospital he had four fits. About six months later he commenced to have further fits, and showed mental deterioration. Encephalography revealed little loss of white matter, but considerable cortical wasting. Mental changes were, however, marked, and he was quite unemployable.

Often the injury of the cortex is not so widespread as in this case. Injury is often fairly localized, leaving a cortical scar which can be inferred where a diverticulum of a lateral ventricle approaches the cortex, or even from localized cortical accumulation of air. Even when the brain has been damaged by the shearing movement of the skull and the poles by contrecoup, the damage may be particularly severe under the site of impact of the blow, where the force has been concentrated, as occurs in the impact of a rapidly moving small object such as a missile. This damage will be greatest in the grey matter, but subjacent white matter is almost certain to be injured as well, with a lesion fanning out from the site of impact, gradually diminishing with distance.

The resultant scar may adhere to the meninges and possibly become an epileptogenic focus. By its subsequent contraction and by the loss chiefly of myelin of the white matter underneath, a traction diverticulum of the ventricle may form, which, as we have seen, can be revealed by air encephalography.

In considering the pathology of these convulsive states we must not always expect to find a clear-cut scar with dural adhesions. There may be no overt cortical scar, and by no means always is the scar, if present, adherent to the meninges. Adhesion between meninges and brain is not essential for post-traumatic epilepsy.

Injuries of the Brain Stem.

Damage of the brain stem is at times a significant feature of brain injury. In this zone are represented many vital functions, and it does not undergo injury lightly, without serious effects on body function. In a case in which the head is subject to sudden violent acceleration or deceleration it is perhaps particularly liable to disturbance, although lesions may be little in evidence at autopsy and their presence be more a clinical than a pathological deduction.

It has been known for some time that hæmorrhages about the aqueduct and elsewhere in the brain stem may be present in fatal cases of head injury. Indeed an old

idea has been resurrected of late and collated with excellent experimental facts, that the phenomena observed in concussion derive from injury of the brain stem. This has been clearly shown experimentally for the vasomotor and respiratory paralyses and loss of reflexes which occur in concussion. That loss of consciousness is of similar derivation has not received universal acceptance, although there is strong support for this view. Yet it is highly probable that it does so result, as may be seen from analogy with other pathological lesions.

CASE IX.—A small pineal tumour caused the death of a married woman, aged thirty-five years, in whom long-standing personality changes, catatonia and trance-like states gradually evolved into a coma from which she could not be aroused. No internal hydrocephalus was present.

Why lesions should occur in this zone in trauma is by no means clear. Such explanations have been suggested as that cerebro-spinal fluid is driven down into the aqueduct under pressure by compression of the cerebral hemispheres. We may, however, note, as Professor Wright has recently pointed out, that the junction of head and neck is liable to considerable angulation with injury to the unsupported head, and that this may be a factor in the localization of injury here.

That these periaqueductal lesions are real I can illustrate from another case.

CASE X.—A boy, aged eight years, was not fully conscious for about seven days after a head injury. He made an excellent recovery and returned to school for a period of six months. After twelve months, however, he developed a peculiar kind of hypothalamic epilepsy, in an attack of which he died. A marked periaqueductal lesion was found which was composed of a vascularized gliotic tissue.

Now one could speak for some time on the psychological changes associated with lesions of the base of the brain and the brain stem, although our knowledge is derived chiefly from experiences with cerebral tumour. But the matter would require considerable examination, although I can say to you that, except for such special areas as those concerned with speech, the nearer a lesion is to the base of the brain, the more likely is it to produce significant changes in the conscious state and in the personality. Although I have no proof, I often wonder to what degree such basal lesions enter into mental states occurring with brain trauma. I think that it is fairly certain that they are responsible for the loss of consciousness, the stupor and the automatic phases which precede full recovery of consciousness. They may indeed at times be responsible for the later psychological changes.

A final static condition of the brain need not be attained for a considerable time after a severe head injury. New vessels and connective tissue are formed and neuroglia proliferates. These vessels themselves are liable to changes, such as thromboses, with œdema and softening, and may be one cause of *spät Apoplexie*. Furthermore, the connective tissue-glia scar contracts, causing tensions; abnormal electrical discharges arise, with a tendency to epilepsy and its psychical equivalents and episodes of abnormal behaviour. When stability is at last achieved, the patient may yet be an effective individual intellectually, even when air encephalography shows much loss of substance. When this loss is very great some degree of dementia is certain.

The final state seems to depend on at least four factors: (i) the extent and position of the damage, (ii) the presence of foci of abnormal brain activity, (iii) the pre-traumatic personality of the patient, and (iv) external social factors, such as compensation, litigations *et cetera*. We can refer briefly to some of these.

I do not know whether you will agree that our normal personality trends manifest themselves in the special neuroses or psychoses from which we can suffer with intracranial disease. But it has seemed to me that we each have our own predilection, as for instance the tendency to undue exhaustibility, to the depression-exaltation swing, to dissociation and hysteria, or to paranoia. In brain disease, be it trauma, tumour, vascular disease or senility, when control of general brain function is depressed, the latent tendency is liable to have its way.

I have been reminded strongly of a familial tendency to certain types of psychosis by two families in which a member of each received a fairly severe head injury. In one the mother had earlier, after a mild hemiplegia, developed severe mania which lasted in a milder form to her death, which resulted from a respiratory infection. Her daughter later had a severe head injury and for a year she too was in a state of subacute mania, although with some insight. In the second family one sister had suffered severe recurrent manic-depressive attacks. Her sister later, after head injury, on recovery of consciousness developed subacute mania, which lasted for several months.

All of us too must have seen many examples of post-traumatic neurasthenia and anxiety states which were plainly but exaggerations of normal personality trends present in the individual beforehand, or forming part of his family pattern.

Conclusion.

In conclusion, you may consider that I have paid too much attention to the pathological basis of post-traumatic sequelae and not enough to the title of this address, "Medical Sequelae of Brain Injury". Nevertheless, it is to this end I have been working and I would summarize certain generalizations from the cases I have quoted:

1. Reasonably effective intelligence may be retained after head injury and yet air encephalography show considerable loss of white matter. We must not, therefore, too lightly dismiss the complaints of such persons as functional or trivial.

2. When the change in the white matter is great some degree of dementia is likely.

3. In some cases white matter is spared while the cortex suffers predominantly.

4. Post-traumatic epilepsy, although associated with scarring, can arise without any adhesion of scar to dura.

5. It is almost certain that the symptoms of concussion are related to brain stem injury. This probably applies as well to the loss of consciousness, delirium and confusion. It is suggested that certain post-traumatic psychoses might arise from such lesions.

6. The personality trends of the patient may determine the types of neuroses and psychoses arising after brain trauma.

7. Late effects, such as *status epilepticus*, may not only arise from abnormal discharges, associated with brain scarring, but from changes in the blood vessels in these scars, with thromboses, softening and oedema.

Reports of Cases.

TOTAL GASTRECTOMY, WITH A CASE REPORT.

By W. MAXWELL,
Sydney.

In the past five years total gastrectomy has come to be performed more commonly, as the immediate survival rate has been vastly improved. From 1942 to January, 1947, Marshall and Brown,⁽¹⁾ of the Lahey Clinic, have carried out 49 total gastrectomies with an operative mortality rate of 16.3%, and they give a balanced view of the indications for this operation. They state that "enthusiasm on the part of some surgeons for major technical procedures has resulted in perhaps unwise employment of this operation without regard to the post-operative morbidity or mortality or its effect upon prolongation of life". They state fairly that total gastrectomy is a valuable procedure and, in properly selected cases, is an extremely useful surgical approach to extensive malignant disease. They refer with disapproval to a small published series of cases of total gastrectomy in which 30% of the patients succumbed to recurrent malignant disease two to three months after operation. A series is quoted of 20 total gastrectomies

carried out by the abdominal route by Waugh and Fahland, of the Mayo Clinic, in 1943, with five operative deaths.

Marshall and Brown prefer the abdominal approach when the oesophagus is not involved, as this type of operation carries less operative risk and morbidity, and a more thorough removal of lymphatic glands can be effected. One may add that the abdominal approach is preferable where the growth extends distally to the region of the pylorus and section of the first part of the duodenum and removal of the subpyloric glands are necessary.

A completely different set of circumstances arises when the oesophagus, abdominal or thoracic, is involved, secondarily or primarily, in the malignant process, and a transpleural approach through the bed of the eighth rib or thereabouts becomes necessary to carry out the operation known as oesophago-gastrostomy. Perhaps too few of the skilled operators in our country have turned as yet to this type of surgery; it may be better if it is not left to surgeons of the enthusiasms referred to by Marshall and Brown.

Clinical Record.

J.J.G., a male, was referred by Dr. G. J. Duncan and admitted to Saint Vincent's Hospital on July 8, 1948. He had his symptoms confused and complained of increasing weakness for the last two years; at one stage he had been treated for "blood pressure". For the last ten months there had been some pain in the epigastrium after meals and the appetite, which had never been good, became worse. He had lost some weight, but did not know how much—his trousers band indicated considerable loss. He had noticed an increasing pallor. There had been breathlessness on exertion for eighteen months.

On examination the patient was pale, with a diminution of subcutaneous fat giving an appearance of much weight loss. There was tenderness in the epigastrium and a hard, movable mass was palpable. The blood pressure was 200 millimetres of mercury (systolic) and 120 millimetres (diastolic). On July 2, 1948, Dr. A. Oxenham gave the following report on X-ray examination: "There is a definite filling defect involving the middle third of the stomach, probably carcinoma." On July 10, 1948, the red cells numbered 3,000,000 per cubic millimetre, the haemoglobin value was 45% (6.8 grammes per centum), the haematocrit reading was 26%. On July 12, 1948, a litre of blood was given.

At operation on July 13, 1948, another litre of blood was given and the abdomen opened by a right paramedian incision, later extended. A carcinoma was found involving the lesser curvature, extending to the pyloric sphincter distally and to within an inch of the cardiac orifice proximally. It infiltrated the anterior and posterior stomach walls extensively, but the left gastric, subpyloric and gastroepiploic glands were surprisingly not involved. The liver had no metastases. In the lesser sac were a few filmy adhesions only. The left triangular ligament of the liver was divided for three inches and the left lobe retracted to the right by a Kocher's retractor. The access afforded was encouraging, and after division of the gastrosplenic ligament with the *vasa brevia* the gastric fundus became reasonably accessible without removal of the spleen, a step advocated by some American surgeons. Total gastrectomy was then commenced with division of the first part of the duodenum, removal of the subpyloric glands and division of the gastric omenta. With the stomach turned over to the left, the left gastric vessels and glands were dealt with in the usual way. This allowed the remainder of the lesser omentum and peritoneal reflections from the cardiac orifice to the diaphragm on each side to be divided, when one and a half inches of subdiaphragmatic oesophagus were cleared. The first loop of jejunum was brought up through an opening in the transverse mesocolon and an anastomosis effected between its apex and the oesophagus above the cardiac orifice by two rows of continuous sutures of fine chromicized gut. The posterior sutures were introduced before the severance of the oesophagus was completed. Another anastomosis was made between the afferent and efferent parts of the jejunum and the margins of the mesocolic aperture were closed around it.

The operating time was two hours and twenty minutes. Glucose infusions replaced the blood drip administration and were continued for three days, in which time penicillin was given. On July 14, 1948, the red cells numbered 4,460,000 per cubic millimetre, the haemoglobin value was 88%, and on July 30, 1948, these were 4,110,000 per cubic millimetre and 80% respectively. The administration of fluids was commenced by mouth on the third day, followed by the usual resection diet, but in smaller quantities, taken very slowly. At the patient's discharge from hospital on August 11, 1948, when he was having an "ambulatory" ulcer diet, he could not take much food at a time, so was instructed to have five small meals per day.

The pathological report revealed adenocarcinoma.

Reference.

⁽¹⁾ S. F. Marshall and L. H. Brown: "Total Gastrectomy", *Surgical Clinics of North America*, Volume XXVII, June, 1947, page 621.

Reviews.

THE TREATMENT OF SMALL ANIMALS.

In the "Index of Treatment in Small-Animal Practice" Hamilton Kirk¹ has produced a text few veterinarians could do without; indeed Part I of the book will be found useful for many medical practitioners.

The book is divided into three parts. Part I contains general information on actinic and radiant heat, and on electric, hormone, vaccine and serum and vitamin therapies. As it is obvious that electrical and ray treatments are to play an increasing part in any practice, the author gives a current description of the various apparatuses, their uses and limitations together with illustrative reports.

Part II is an index of therapeutics and supplies a full description of the lines of treatment to adopt, listed in an alphabetical order of symptoms. Generous use is made of proprietary trade names and their value or deficiencies are freely stated. In difficult conditions such as eczema the time-honoured remedies are given as well as recent references to anti-histamine therapy with "Benadryl".

Part III consists of general instruction in methods of handling, nursing and administering medicines to small animals gained from years of experience. An addendum is devoted to the use of penicillin, the later sulphonamides and gammexane. It is pleasing to note that the necessity for adequate doses is stressed to prevent acquired resistance to certain drugs.

The book has been carefully prepared with its main aim as a quick reference for a busy veterinary surgeon, but it also contains valuable information on comparative medicine which would be of interest to the medical practitioner.

FRACTURES AND ORTHOPÆDICS FOR NURSES AND MASSEUSES.

The second edition of "Fractures and Orthopaedic Surgery for Nurses and Masseuses" by Arthur Naylor² presents many improvements on the first edition, but the main criticism of the work is still that perhaps it contains too much detail for the average nurse and not enough for masseuses. However, it is admittedly difficult to fulfil adequately in one book the divergent requirements of both nurses and masseuses and certainly the author does his best to satisfy both groups.

Chapters devoted to the treatment of fractures and plaster of Paris technique are excellently written and profusely illustrated by both photographs and diagrams. It is pleasing to note that much more mention is made of the value of occupational therapy in its various forms, and this phase of after-treatment is shown by a well-chosen series of photographs.

Clear and concise descriptions of the various orthopaedic maladies will be of great value to nurses working in ortho-

¹ "Index of Treatment in Small-Animal Practice", by Hamilton Kirk, M.R.C.P.S.; 1948. London: Baillière, Tindall and Cox. 9" x 5½", pp. 786, with illustrations. Price: 40s.

² "Fractures and Orthopaedic Surgery for Nurses and Masseuses", by Arthur Naylor, Ch.M., M.B., M.Sc. (Sheff.), F.R.C.S. (England), F.R.C.S. (Edinburgh), foreword by Ernest Finch, M.D., M.S. (London), F.R.C.S. (England); Second Edition; 1948. Edinburgh: E. and S. Livingstone, Limited. 8½" x 5", pp. 316, with many illustrations. Price: 17s. 6d.

pædic wards and will enable them to face their examiners with confidence. Tutor sisters and doctors who lecture to nurses will find the book of value, for most of its 251 clear illustrations lend themselves readily to epidiascopic reproduction.

RADIOTHERAPY AND CANCER.

A BOOKLET of eighty pages with the comprehensive title "Radiotherapy and Cancer" has come to hand.¹ The authors state that the booklet has been prepared primarily for their own use, and that it is being distributed to the profession in the region from which their patients come.

The physics of radiotherapy is dealt with in three and a half pages, radiobiology in four pages, and the succeeding pages of the first part deal with staging and curability of tumours and the possible methods of treatment.

The second part lists sites in which neoplasms occur, and gives a classification of tumours concerned. There is no description of pathological or clinical features, nor does the method of treatment receive discussion other than a bare statement of the nature of the method advised in the particular stage of disease present.

The booklet is too scrappy to be of significant value to either the practising radiotherapist or the post-graduate student.

EAR, NOSE AND THROAT NURSING.

THE fourth edition of "Ear, Nose and Throat Nursing" by Jas. Hardie Neil and T. Hardy Neil has recently been published.² It not only meets an urgent need for an introduction to the nursing of ear, nose and throat patients, but is also a reference book in this subject for senior nurses.

As a guide to the general routine of an ear, nose and throat department for resident medical officers it should be of considerable assistance. Some of the more advanced notes are contained in a series of appendices. These include illustrations of bronchial anatomy and a summary of sulphonamides and antibiotics by Dr. Lawrence Ludbrook, pædiatrician of the Auckland Hospital. The comprehensive list of instruments with illustrations for the preparation of dressing and examination trays, as well as the armamentarium necessary for larger operative procedures, will be found helpful. Last, but not least, is a summary, "The Testing for the Loss of Capacity for Hearing of Speech". This is very welcome in view of the recent prominence given to audiometry.

DISEASES OF THE CHEST.

THE third edition of the well-known "Introduction to Diseases of the Chest" by James Maxwell now appears, and owing to the recent developments of sulphonamide and penicillin therapy the work has been revised to bring the chapters on treatment up to date.³ In the preface the author stresses the "necessity for routine X-ray films before a negative diagnosis can be made", no matter what the physical examination may reveal. Nevertheless he also insists on very thorough history taking, followed by careful physical examination, and his instructions for such examinations are meticulous. Instead of having illustrations printed throughout the book a series of some sixty-six figures, most of these being reproductions of skiagrams, appears at the end of the book, and as they are presented in a logical sequence students will find the arrangement helpful.

As in the previous edition, hydatid disease of the lung is merely mentioned, a disappointing feature from an Australian viewpoint. However, other major chest maladies are excellently described and students and doctors alike will find this well-written work a welcome addition to their bookshelf.

¹ "Radiotherapy and Cancer", by A. G. C. Taylor, M.R.C.S., L.R.C.P., D.R., F.F.R., Joan Lasseter, M.B., Ch.B., D.R., and T. K. Morgan, M.B., M.R.C.S., D.M.R. (T.); 1948. London: H. K. Lewis and Company, Limited. 8½" x 5½", pp. 84. Price: 7s. 6d.

² "Ear, Nose and Throat Nursing", by Jas. Hardie Neil, C.B.E., D.S.O., F.R.A.C.S., F.A.C.S., and T. Hardy Neil, D.L.O., F.R.A.C.S.; Fourth Edition; 1948. Auckland: Auckland Service Printery. 8½" x 5", pp. 160, with illustrations.

³ "Introduction to Diseases of the Chest", by James Maxwell, M.D. (London), F.R.C.P. (London); Third Edition; 1948. London: Hodder and Stoughton, Limited. 8½" x 5½", pp. 346, with illustrations. Price: 12s. 6d.

The Medical Journal of Australia

SATURDAY, APRIL 16, 1949.

All articles submitted for publication in this journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations and not to underline either words or phrases.

References to articles and books should be carefully checked. In a reference the following information should be given without abbreviation: initials of author, surname of author, full title of article, name of journal, volume, full date (month, day and year), number of the first page of the article. If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full date in each instance.

Authors who are not accustomed to preparing drawings or photographic prints for reproduction are invited to seek the advice of the Editor.

THE MEETING OF THE FEDERAL COUNCIL.

EACH succeeding meeting of the Federal Council of the British Medical Association in Australia has its peculiar highlight of importance. The meeting of March 1 to 4, 1949, which is reported in this issue, is no exception. In some respects it marks the beginning of a new chapter in its history, because, as indicated in this journal on February 5, 1949, the Minister for Health, the Right Honourable Senator N. E. McKenna, recently broke off negotiations with the Federal Council as representing the medical profession of the Commonwealth, declaring that the Government would, within the limits of constitutional power, proceed to put its plans into operation. As explained in these columns a few weeks ago, this happening was used by Sir Henry Newland, President of the Federal Council, as providing a suitable time at which he might retire from the Council and seek respite from the onerous duties of his office, after many years of service. The Council thus begins its new chapter under its new President, Dr. T. E. Victor Hurley, C.B., C.M.G., a man who has taken a prominent part in the corporate life of the medical profession and who is known throughout Australia and beyond its borders for achievement and leadership in the Australian forces in the First and Second World Wars. The subject matter of this new chapter is very like that of the last, and the Federal Council will pursue it with the same confidence that it has always had in the rightness of its cause and in the ability of its leader.

The two subjects of the greatest moment on the agenda of the recent meeting were *The Pharmaceutical Benefits Act* and *The National Health Service Act*. As parliamentary enactments these two measures are, of course, quite distinct, but from the point of view of the medical profession and also of the public they are closely related—they both strike a blow at the freedom of the individual, whether he is doctor or patient, and neither is likely to fulfil the object implied by its name. Since the Federal Council meeting was held *The Pharmaceutical Benefits Act* has been amended and provisions which had been forecast in the daily Press as likely to be included in the regula-

tions, have been incorporated in the Act. The main provision is that doctors who wish to prescribe for their patients any drug which is included in the Government's formulary must use the government forms for their prescriptions. If a doctor fails to do this he is to be liable to a fine not exceeding £50. This is regimentation and coercion of the medical profession. It is civil conscription and it affects the general public as well as their medical attendants. This last point is not widely appreciated. The plain truth is that no one in the community will be able to obtain certain medicaments ordered by a doctor without accepting a medical benefit from the Government. If the doctor must prescribe on a government form, the prescription will be taken to a pharmacist, who will be paid for the product ordered, not by the patient who may wish to pay, but by a coercive government which insists on paying whether the patient likes it or not. The patient, moreover, knows that in these circumstances his prescription on a government form passes into the hands of the Government. The Government (a government official) becomes aware that the patient has consulted a doctor; this is the patient's own concern and he should have the right of determining whether anyone other than the doctor and the pharmacist should be aware of the consultation. If the patient is not bound to accept a government benefit he is free to keep his own counsel. *The Pharmaceutical Benefits Act* does not become law until it is proclaimed, and it will be seen from the published report of the recent meeting that the Federal Council will take whatever steps are necessary to test the legality of the whole affair.

In regard to *The National Health Service Act* the Federal Council had before it the reply from the Minister to the Federal Council's letter of December 13, 1948, which was published in these columns on February 5, 1949. The Federal Council then drafted a letter which was sent to the Prime Minister; this letter appears in the report of the meeting on page 532. The Prime Minister has replied to the President of the Federal Council in the following terms:

[COPY.]

COMMONWEALTH OF AUSTRALIA.

Prime Minister,
Canberra,
10th March, 1949.

Victor Hurley, Esq., C.B., C.M.G., M.D., F.R.C.S.,
President,
Federal Council of the British Medical Association in
Australia,
135 Macquarie Street,
Sydney, N.S.W.

Dear Mr. Hurley,

I acknowledge receipt of your letter of 3rd March, 1949, in which you convey the views of the Federal Council of the British Medical Association on the Government's National Health Service Act and medical benefits proposals.

In reply, I would emphasise that the medical benefits scheme in which the Government has asked your members to co-operate is a simple, straightforward proposal. Patients will continue as at present to go to, or be visited by, the doctor of their choice and the relationship between the patient and his doctor will be precisely the same as it is now. Those doctors who come into the scheme, however, will receive from their patients only half the fee scheduled for the service they have given; the other half of the fee will be paid to the doctors by the Commonwealth.

To suggest that these proposals would mean "the subjection of doctors to the Department of Health" and that their "immediate effect must be to place the profession under the control of the Government" is absurd. Doctors will remain free to stay out of, participate in, or withdraw from the scheme; those participating will be obliged merely to observe the essentially simple rules necessary for accounting purposes.

Nor will the doctor, when claiming payment from the Commonwealth, state either the complaint for which the patient has been treated or the treatment given. Details of the claim form have not yet been finally settled; but, as my colleague, the Minister for Health, pointed out to you at the conference in Melbourne on 26th October, 1948, what the Government has in mind is a form similar to that recommended by the New Zealand Medical Services Committee. Nothing in that form in the slightest degree justifies your Council's objection that the scheme will involve an "intrusion by the Department into the confidential relationship between doctor and patient". It is not contemplated that doctors should be required to keep clinical records. Apart from cases of fraud which would be dealt with by ordinary legal process, the only possible cases in which a doctor might be required to furnish evidence of a professional nature would be those involving allegations of serious malpractice under the Medical Benefits Scheme—and then only under the most stringent safeguards.

Unless doctors participating in the scheme feel that in the standard of treatment given they can discriminate between the patients receiving the medical benefit and those paying the full fee, there would not appear to be any reason why they should wish to combine private practice with practice under the Medical Benefits Scheme. However, provided the Government can be assured that patients wishing to receive the medical benefit will receive it in full, the Government would be prepared to consider whether practice outside the scheme might be undertaken by doctors participating in it.

It is true, as your Council observes, that under the scheme some clerical work would have to be done, but generally this would be done by the doctor's secretary. In any case the work would not be burdensome; a single line entry for each service given, the submission of a monthly claim, and the reduction of the patient's account, are all that would be required. This is all the Government is asking doctors to do by way of co-operation in the scheme.

If the alternative your Council now suggests—the refund system—were adopted, doctors would presumably do no more than they do now—issue receipts for fees received. Clearly, doctors would then be making no contribution to the benefit scheme at all; and to talk of "co-operation" on those terms is meaningless. Furthermore, in recommending the refund system, your Council is proposing a scheme that would still leave the burden of payment of the doctor's account on the patient until the patient had obtained the refund from the Government. The Government's plan is aimed directly at the relief of patients from part of this financial burden and is designed to achieve this end in a simple manner. Your proposal would mean that millions of claims by patients would have to be made as against some five or six thousand monthly by doctors under the government scheme. In the interests of patients and the community generally, the Government insists that the Medical Benefits Scheme be simple and efficient.

Your Council must be aware that after several years' experience in New Zealand of the refund method you propose a committee composed of representatives of the New Zealand Administration and the British Medical Association has now recommended that the method be superseded by a scheme akin to the one the Commonwealth is proposing, i.e., one in which the doctor and not the patient makes the claim on the Government.

Your Council favours the establishment of health centres for group practice, but objects to the establishment of Government-controlled centres. What your Council is in effect proposing is that the question of control should be allowed to stand in the way of the establishment of health centres and that the Government should bind itself not to establish government-controlled centres even if it is obvious that they would afford the most effective means of meeting the medical needs of particular groups of persons and of particular areas. The Government cannot accept a prohibition of this kind.

In the final paragraph of your letter, you list a number of "positive items of health policy" which you say your Council communicated to the Government in 1947 and which your Council feels should be given "urgent priority over all other measures of public health".

The Minister for Health has pointed out to me that this list is by no means identical with the one submitted in 1947; the latest list includes items not submitted before. Nevertheless, there is nothing in either list that is not already covered by the Government's plans for which the recently passed National Health Services Act is one of the enabling measures. Indeed, the Government has already taken action on important measures of positive health policy. For example, arrangements are being made with the States

for a large-scale campaign against tuberculosis; the Commonwealth scheme for rehabilitation of disabled members of the community has been in operation for some time; the Commonwealth is making biological products available without charge for immunisation against diphtheria and whooping cough; the Commonwealth Serum Laboratories are undertaking the manufacture of new and advanced biological and other products; a Division of Child Health is to be established; District Health, Acoustic and X-Ray Laboratories are being expanded; a grant of £60,000 a year is being made to the National Health and Medical Research Council; to the School of Public Health and Tropical Medicine—a Commonwealth activity at Sydney University—new units are being added, such as the Industrial Hygiene Unit and the Institute of Child Health; the Australian National University has appointed professors and granted fellowships for medical research, and, as soon as possible, a medical research school within that University will be fully established; £72,000 is provided annually for National Fitness.

Your Council should be aware that it is physically impossible to give effect immediately to all of the positive measures enumerated in your letter: for example, all governments in Australia have planned large-scale increases in hospital accommodation, but the rate of actual construction of these institutions must be related to the existing urgent demand for housing and other works. In saying that the positive measures should be given priority, your Council is surely not suggesting that the Medical Benefits Scheme which the Government, with the co-operation of the medical profession, is in a position to introduce without delay, should be postponed merely because the other measures mentioned cannot at once be made fully effective. It will be obvious that your Association's views on the importance of the positive measures can in no way justify its refusal to co-operate with the Government in the Medical Benefits Scheme.

Complementary to the positive measures referred to above, are the schemes for financial assistance to patients which have been introduced by the government: Hospital Benefits, Tuberculosis Allowances, Mental Institution Benefits, and Pharmaceutical Benefits. These schemes, like the Medical Benefits Scheme, do not depend for full development on building materials and other scarce resources, and it has been possible to make Hospital Benefits and allowances to sufferers from tuberculosis fully effective from the time the schemes were introduced. Agreements on benefits in respect of inmates of mental institutions are now being made with the States, and these too will be fully effective as soon as the scheme begins to operate. Pharmaceutical Benefits also would have been fully available from 1st June, 1948, if your Association had not decided to deny them to the people of Australia (including the aged and invalid pensioners for whom your Council professes some concern) in the same spirit of opposition it is now showing towards the Medical Benefits Scheme.

I should like to add that the Government has already gone a long way to meet your Association's point of view. The essential features of the Government's medical benefits proposals were in fact suggested to the Minister on behalf of your Association by the President, Sir Henry Newland, in his 1947 memorandum on the "Fee-for-Service Method of Payment of Doctors", namely, schedule of fees covering a full range of services, part payment by patients, and (at least by implication) the presentation of claims by the doctor to the Government. It is this fact that makes the more recent attitude of your Association incomprehensible; and I find it difficult to understand the motives underlying your Council's refusal to co-operate in the Medical Benefits Scheme.

The Government cannot permit the introduction of the Medical Benefits Scheme to be delayed by interminable discussion. It is the Government that must accept responsibility to the community for whatever scheme is adopted. This I would suggest very seriously is a fact your Council does not appear to appreciate fully. Indeed, your Council's view seems to be that the British Medical Association and not the Government should decide the conditions under which any National Health Service should operate.

Yours sincerely,

(Sgd.) J. B. CHIFLEY, Prime Minister.

An amendment of *The National Health Service Act* is forecast for the May session of Parliament. We can only guess at what form the amendment is likely to take. In the meantime it is important that the members of the Branches shall know what to do. First of all members must know what conditions the Federal Council thinks

should surround any fee-for-service scheme of government benefits. Secondly, members are advised not to cooperate in any fee-for-service scheme which has not the approval of the Federal Council. Thirdly, they will be well advised to refrain from replying to any approach to them as individuals by the Government, unless they have obtained the approval of their Branch Councils. Here again, members may feel assured that the Federal Council is not neglectful of the legal aspect of this question. With this meagre statement it is necessary at present to be content. We may add, however, that there is no reason whatever to be downhearted.

Two considerations remain. One is to seize every possible opportunity of spreading among all persons of every kind of political creed the gospel of individual freedom. This fight, for fight it is, is one for every person who wishes to live his own life as he may choose to live it. We know that freedom and service go hand in hand. No group of persons knows this better than the members of the medical profession, whose whole existence is based on service, but on service freely chosen and given of a free heart and not of compulsion. The doctors of Australia have made it perfectly clear that they wish to create for the people of Australia a medical service that will be of the highest quality and available to everyone. The people must be made to understand what the aims of the medical profession are. In this regard the medical practitioner is his own best publicity agent. We also understand that the Publicity Committee of the Federal Council has other plans to extend what is now being done. The other consideration of the two mentioned as remaining is the new Independence Fund. This is not only a fighting fund, but will be used also to give financial help to any member of the Association who is directly affected in his practice through direct government action. It is likely that large sums of money will be required. We hope that the response will be prompt and liberal. The fund is being wisely planned so that it may be closed when thought necessary and the unexpended portion of the moneys will be returned *pro rata* to the contributors. At the outset let us remember the old Latin tag: *Bis dat qui cito*.

Current Comment.

THE RH BLOOD GROUPS AND THEIR CLINICAL EFFECTS.

THE discovery of the Rh factor in human blood led to the solution of two hitherto unrelated problems. These were the condition known as *erythroblastosis fetalis*, now called *haemolytic disease of the newborn*, and the *haemolytic reactions* that occasionally follow blood transfusions even of apparently compatible blood. For some years before these discoveries were made an interest in *erythroblastosis fetalis* had been fostered by paediatricians in both Great Britain and America. The cause of the disease was quite unknown and its peculiar familial incidence presented a very baffling problem. In 1940 Landsteiner and Wiener reported the finding of a hitherto unrecognized factor in human blood which they called the Rhesus or Rh factor. In the same year Wiener and Peters showed the presence of Rh antibody in the blood of patients who had suffered *haemolytic reactions* following transfusions. In 1939 Levine and Stetson had found an atypical immune agglutinin in the serum of a woman who had delivered a stillborn child, and in 1941 Levine and his colleagues proved that the formation of Rh antibody by an Rh-negative woman fre-

quently resulted in stillbirth or in one of the syndromes of *erythroblastosis fetalis*. These extremely important discoveries, coming as they did in wartime when any matter relating to blood transfusion was of the utmost importance, were taken up and extended rapidly. During the next few years a whole field of interesting and intricate discovery was opened up by the work of R. R. Race and his colleagues in England, and A. S. Wiener in the United States. It became apparent that there was not merely one, but a whole series of Rh factors. In 1944 R. A. Fisher put forward an hypothesis which explained the relations of the different subgroups of the Rhesus factor and which has been supported by the subsequent discovery of the Rh genotypes and antibodies whose existence he had predicted. Fisher's nomenclature will probably replace the "shorthand symbols" used previously.

It is now recognized that Rh tests should be made on all patients who are to receive transfusions of blood. Every hospital pathologist, and for the matter of that, every medical practitioner, will wish to be conversant with the most recent developments in this work. The appearance of a Medical Research Council Memorandum entitled "The Rh Groups and their Clinical Effects", by P. L. Mollison, A. E. Mourant and R. R. Race, is most welcome. It provides a clear and authoritative statement of the present position of our knowledge of the subject. The first section, by Dr. Race, of the Medical Research Council Blood Group Research Unit, deals with the Rh groups; the second section entitled "Clinical Considerations" is the work of Mollison, of the Medical Research Council Blood Transfusion Unit; and in the third section the practical details of Rh testing are described by Mourant, of the Ministry of Health Blood Group Reference Laboratory.

In the first section Race describes the Rh groups in detail; more detail perhaps than is necessary for a practical understanding of them. This section, he writes, "is addressed particularly to laboratory workers and to those interested in the theoretical aspect of this fascinating subject". The notation introduced by Fisher (the "CDE" notation) is used throughout, as it is in Race's opinion the only notation capable of fully designating the genes, compound genes or chromosomes and the genotypes. It is, however, somewhat cumbersome to use in speech. For this reason and for the sake of completeness the corresponding "shorthand symbols" (R₀, R₁, R₂ and so on) are given in one of the tables in this section. Some of these symbols were introduced by Wiener and some by British workers. In the second section Dr. Mollison deals with the ways in which iso-immunization to Rh occurs, the detection of sensitization, the effects on the fetus of sensitization of the mother, and the differential diagnosis of *haemolytic disease of the fetus and of the newborn*. He also discusses the premature termination of pregnancy when the birth of an affected infant is expected, and the treatment of the affected infant, giving precise and practical detailed descriptions of transfusion via the umbilical vein, the internal saphenous vein and the veins of the scalp. A plastic catheter for exchange transfusions via the umbilical vein is described. The very difficult question of the advice to be given to parents of affected children regarding possible future pregnancies is dealt with concisely, but with great care and completeness; the dry painstaking scientific approach conveys an unspoken human sympathy. In the third part of the pamphlet Mourant gives a detailed description of methods of testing and of certain ancillary techniques. Tests of cells and of sera both in saline media and in protein media are described and also the technique of the anti-human globulin test. A subsection entitled "Specialised Rh Tests and Techniques" deals with the selection of donors, the determination of Rh-genotypes, the testing for individual antibodies, the technique of differential agglutination tests and the preparation of an anti-human globulin serum.

Anyone who has tried to keep abreast of the voluminous literature on the Rh factor must marvel and rejoice to find so much gathered here under one cover. Those who have the enthusiasm and the time to read widely will find this pamphlet a most useful guide to the literature; and the busiest doctor should find time to read so clear, brief and informative a survey of the subject.

Abstracts from Medical Literature.

PATHOLOGY.

Periarterial Fibrosis in Disseminated Lupus Erythematosus.

GUNNAR TEILUM (*The American Journal of Pathology*, March, 1948) states that hyperglobulinemia, periarterial fibrosis of the spleen, and the wire loop lesion of the glomeruli in *lupus erythematosus disseminatus* are all considered to be expressive of a primary allergic hyperglobulinosis in the reticulo-endothelial system, after the analogy of the morphological immunity reaction in atypical and experimental amyloidosis, Boeck's sarcoid, and other conditions, which was previously described by the author. Periarterial fibrosis of the spleen is thus produced in various conditions with hyperglobulinemia (with or without any demonstrable increase in the number of plasma cells) and displays all transitions to atypical amyloidosis, which, as an underlying cause, also has a stimulation of immune mechanisms with hyperglobulinemia. Like the periarterial deposits and the collagenic sclerosis (diffuse scleroderma), the characteristic "wire loop lesion" occurring in many cases of *lupus erythematosus disseminatus* must be looked upon as an alteration closely related pathogenetically to atypical amyloidosis, whereas focal, and in the narrowest sense allergic, lesions (miliary granulomata in the serosa, nodular necroses, focal allergic pneumonia) are predominant in other cases or may be present in addition to the lesions first mentioned. From the point of view of immunobiology these two groups of alterations may be considered expressive of a positive anergy and an allergy, respectively. In some cases also administration of sulphonamides may give rise to a hyperglobulinotic (paramyloid) syndrome (plasmocytosis, hyperglobulinosis, paramyloidosis in different organs, possibly uræmia), in contrast to the well-known hypersensitive reactions to sulphonamides.

The Composition of Aspirated Sternal Marrow.

J. N. DAVIDSON, I. LESLIE AND J. C. WHITE (*The Journal of Pathology and Bacteriology*, January, 1948) have investigated the composition of aspirated sternal marrow with regard to general histology, cytological distribution and content of ribonucleic and deoxyribonucleic acids by chemical and histochemical methods in (a) a group of 15 normal individuals and (b) patients suffering from various blood dyscrasias. The investigations have been repeated at intervals during treatment in three cases of pernicious anaemia, two cases of macrocytic anaemia, one case of nocturnal haemoglobinuria and one case of chronic myeloid leukaemia. The accuracy of the methods in relation to the nature of aspirated sternal marrow is discussed. In the abnormal bone marrow the content of both forms of nucleic acid often considerably exceeds the ranges for the normal series. Increase in the amount of ribonucleic acid, and of deoxyribonucleic acid to a lesser extent, is particularly related to hyperplasia of the marrow and an increase in number of the more primitive cell types. From cyto-

chemical evidence the ribonucleic acid is located chiefly in the cytoplasm and nucleoli of the younger free cells, and the amount diminishes progressively with maturation. Deoxyribonucleic acid may be elevated in amount to a greater extent than ribonucleic acid in hyperplastic marrows, with predominance of partially mature cells. Increased maturity of the marrow as a result of treatment is associated with a fall in the content of both forms of nucleic acid to within the ranges of the normal series. In pernicious anaemia the fall in nucleic acid levels is greatest during the reticulocyte response to hemopoietic substances and is associated with the maturation of primitive cells possessing large nucleoli and basophilic cytoplasm and with disappearance of the megablasts. Return to normal cellularity and architecture is more gradual and the nucleic acids then come to lie within entirely normal limits. The relationship of the liver principle and of folic acid to the normal maturation of hemopoietic cells is discussed, with particular reference to the metabolism of ribonucleic acid and to normal mitosis.

Extraabdominal Desmoid Tumours.

JAMES E. MUSGROVE AND JOHN R. McDONALD (*Archives of Pathology*, April, 1948) present a detailed clinicopathological study of 34 cases of extraabdominal desmoid tumour. A similar number of cases of low-grade fibrosarcoma have been studied by the authors in an attempt to formulate criteria which will aid in the microscopic differentiation of the two tumours. The extraabdominal desmoid tumour is the same pathogenic entity as the desmoid tumour occurring in the musculo-aponeurotic structures of the abdominal wall. The desmoid tumour is a benign fibrous neoplasm, which has the peculiar characteristic of locally invading and destroying the adjacent striated muscle. It does not metastasize and there is no evidence in the present study that it undergoes sarcomatous change. Two theories of origin have been presented, namely, that of a relationship to trauma and that of an endocrinological basis. Of the 34 patients, 41% definitely linked the onset of the tumour with some previous trauma. However, only three of the 34 tumours showed a trace of haemosiderin on microscopic examination. Thus the histories tend to corroborate the traumatic etiological basis, while the microscopic observations tend to disprove it. There is strong evidence that the endocrine glands may play a part in the origin and "physiology" of these tumours. The extraabdominal desmoid, like its counterpart in the abdominal wall, is found more often in the female, the ratio in the present series being 2.4:1.0. In an attempt to differentiate between the desmoid tumour and low-grade fibrosarcoma the following microscopic criteria are important: (i) Encapsulation. A well-circumscribed, encapsulated fibrogenic tumour should be considered malignant until proved otherwise. (ii) Cellularity. An acellular fibrous tumour will usually be benign, while a high degree of cellularity definitely points toward malignancy. (iii) Mitotic figures. Fibrogenic tumours not showing mitotic figures are benign, while those with numerous mitotic figures are malignant. However, tumours showing infrequent mitotic figures cannot be placed in either the benign or the malignant class on the basis of this characteristic

alone. (iv) Pathological mitotic figures. One or more pathological mitotic figures indicate malignancy. (v) Tumour giant cells. These cells are found only in the malignant fibrogenic lesions. (vi) Variation in cellular size, shape, staining and nucleoli. As the variation in these cellular features increases so does the tendency toward malignancy.

A Morphological Study of the Cardiac Conduction System.

DANIEL J. GLOMSET AND RICHARD F. BIRGE (*Archives of Pathology*, February, 1948) state that a sino-atrial node does not exist in the *sulcus terminalis* of man, dog, rhesus monkey, swine, sheep, cattle or horse; nor did the authors find in the hearts of the same species a special atrio-ventricular muscle conduction bundle. However, in sheep, cattle, swine and horse there is present a distinct ventricular bundle composed of about half nerve tissue and half altered muscle fibres. This bundle begins in the atrio-ventricular fibrous ring, has a stem and a right and a left branch, and terminates in a subendocardial and an intramyocardial network. No structure analogous to this bundle exists in the ventricle of man, dog or rhesus monkey. The bundle described by His appears to have been a group of ordinary muscle fasciculi of the left side of the septum, originating in the central atrio-ventricular fibrous ring and spreading out over the septum as the fasciculi run toward the apex. There is no atrio-ventricular node in the heart of man, dog or rhesus monkey. The structure which has been described as the stem of the His bundle of man is the superavalvular part of an ordinary muscle fasciculus—the ridge fasciculus. The right branch of the His bundle is the intravalvular part of this ridge fasciculus. The fasciculus does not give off a left branch. However, experimental injury done to the upper part of the ventricular septum in animals and man does bring about heart block and bundle branch block, and more or less extensive lesions have been found in the upper part of the ventricular septum of man in heart block and bundle branch block. The lesions observed in the ventricles of the examined hearts in places other than the upper part of the interventricular septum do not appear to be causally related to the conduction disturbances in the cases which form the basis of this communication.

Coarctation of the Aorta and the Aortic Isthmuses.

J. L. BREMER (*Archives of Pathology*, April, 1948) reemphasizes the distinguishing characteristics of the two main types of coarctation—the congenital or foetal type I and the adult type II of Bonnet. Many of the variations of both types (called collectively type IV) are shown to depend on the extent of the normal cranial migration of the left subclavian artery, or less commonly on that of the vertebral artery. The adult type of coarctation is due to a fault of development in which the processes of closure of the *ductus arteriosus* normally occurring at birth extend abnormally to the aorta. The congenital type of coarctation is connected with the presence of the aortic isthmus. This isthmus and its counterpart on the right side, the less well-recognized right subclavian isthmus, also are connected with the

normal closure and degeneration of paired embryonic vessels, the segments of the two dorsal aortas between the third and fourth arches, lost during the rearrangement of the primarily symmetrical aortic arch system at six to eight weeks. The subclavian isthmus is expanded by the constantly increasing volume of blood flowing through the growing artery. The aortic isthmus is located in the relatively stagnant section between the aortic arch and the pulmonary artery. Depending on the volume and the rate of the flow of the blood circulating through this section, the isthmus may expand gradually until birth and then rapidly, or, with minimal volume, it may continue closing even to obliteration, the closure resulting in aortic coarctation or atresia.

MORPHOLOGY.

Apocrine Sweat Glands in Mammary Gland.

H. BUNTING (*The Anatomical Record*, May, 1948) describes tubular structures of the human breast which resemble apocrine sweat glands. These were studied by a number of cytochemical means. Previous investigators have shown that these structures, found in almost every normal breast, communicate, unless they are cystic, with the lactiferous duct system. Their similarity to apocrine sweat glands, which has frequently been noted, rests chiefly upon the character of the epithelium, which is tall and strongly eosinophilic. The present study shows that these cells possess iron-containing granules and lipid droplets identical with similar bodies encountered in the epithelium of apocrine sweat glands. In the mammary epithelium no similar iron granules are demonstrable, nor is any comparable lipid noticeable in the resting mammary cells. Other features of these structures, such as the distribution of alkaline phosphatase, are common to both breast and sweat glands. Duplication of the characteristic properties of apocrine sweat glands by a "degenerative" change in the mammary epithelium, as some investigators have maintained, would seem to be an unlikely explanation of these structures. It is concluded that they represent apocrine sweat glands, which are normal constituents of the mammary gland.

Pigment Cells in Epidermis.

R. E. BILLINGHAM (*Journal of Anatomy*, April, 1948) gives an account of the anatomical basis of pigmentation of mammalian skin. He has demonstrated that, although pigment granules are found in most "ordinary" epidermal cells of pigmented skin, they are not of endogenous origin, but are derived from branched cellular elements which have been called pigmented dendritic cells. These branching cells are located at the level of the basal-layer cells of the epidermis. From them branches are given off which travel along the intercellular spaces between the ordinary epidermal cells, dichotomizing frequently, and ultimately terminate in the form of "caps" or "end-buttons" closely applied to the boundaries of ordinary epidermal cells. Evidence is presented which indicates that the pigment granules are elaborated within these dendritic cells and are passed on

to the ordinary epidermal cells across the end-caps. This hypothesis accounts for the well-known initial polar-capping distribution of pigment within the epidermal cells. Dendritic cells have a cell-lineage of their own and are not derived from ordinary epidermal cells of the basal layer as a functional modification. Branched cellular elements which are similar in all respects to pigmented dendritic cells, save that they lack the melanogenic properties characteristic of the latter, have been demonstrated in the non-pigmented epidermis of man, the guinea-pig and the rabbit. These have been called white dendritic cells. It is suggested that dendritic cells (both types) almost certainly fulfil some physiological function in the epidermis other than melanogenesis. The relationship between the white dendritic cell and the "cell of Langerhans" is discussed, and it is concluded that they are identical. The theory that these cells have connexions with the nerves of the skin is not supported. It is concluded that the mammalian epidermis is a compound tissue composed of at least two distinct cellular elements: the dendritic cells and the ordinary epidermal cells.

Movement of Particles from Peritoneal Cavity to Lymphatics of Diaphragm.

P. H. SIMER (*The Anatomical Record*, July, 1948) found that small particles, like those of Indian ink and stained yeast cells, ranging up to a maximum diameter of 5μ to 6μ , pass freely from the peritoneal cavity into the subperitoneal lymphatics of the diaphragm. They appear to force their way between the contiguous borders of the mesothelial cells of the peritoneum and the endothelial cells of the lymph vessels. They are carried from the diaphragm along the normal pathways of lymph flow from this organ: ventrally through sternal lymph trunks which accompany the internal mammary blood vessels and drain into the anterior mediastinal lymph nodes; or dorsally through lymphatics in the crura of the diaphragm to lumbar lymph nodes.

Nerve Supply of Knee Joint.

E. GARDNER (*The Anatomical Record*, May, 1948) gives an account of the nerve supply of the human knee joint based on dissections of adult knee joints and on serial sections of fetal joints. The articular nerves are derived from the femoral, obturator, tibial, common peroneal and recurrent peroneal nerves. Cases recorded in the literature indicate that on rare occasions the accessory obturator nerve also supplies the knee joint. The femoral nerve through its saphenous branch, and also through its branches to the vastus medialis, intermedius and lateralis muscles, supplies the suprapatellar recess, the patellar periosteum, the antero-medial and antero-lateral portions of the joint capsule, the infrapatellar fat pad and vessels to the femoral and perhaps the tibial condyles. The tibial nerve supplies the posterior, medial and lateral portions of the joint capsule, the infrapatellar fat pad, the tibial periosteum, the superior tibio-fibular joint and vessels supplying the tibial and perhaps the femoral condyles. The common peroneal nerve supplies the antero-lateral portion of the capsule, the infrapatellar fat pad, the tibial periosteum and vessels to the lateral tibial and perhaps the lateral femoral condyle. The recur-

rent peroneal nerve supplies the tibial periosteum, the tibial tuberosity, the infrapatellar fat pad and the superior tibio-fibular joint. The obturator nerve supplies the popliteal vessels, the superior part of the postero-medial capsule, the antero-medial part of the capsule, the infrapatellar fat pad and vessels to the medial femoral condyle. Many of the nerve fibres undoubtedly end in association with blood vessels supplying the capsule and epiphyses. Other types of endings could not be deduced, except for the fact that the concentration of fibres in the posterior part of the capsule makes it possible that proprioceptive endings are located here, as they are in other animals studied.

Medio-Palatine Bones.

WOO JU-KANG (*American Journal of Physical Anthropology*, June, 1948) has studied the hard palate in 1548 skulls to determine more accurately the occurrence of one of the rarest of cranial anomalies. Two cases of the very rare anomalous complete medio-palatine bones were found. The bones in the first case extend from the incisive sutures to the transverse palatine sutures, and those in the second case are much smaller, situated at the antero-medial part of the palatine processes of the maxillae. Seventeen cases of incomplete medio-palatine bones, including those limited by almost complete to mere traces of lateral longitudinal palatine sutures in the maxillae, were found. The lateral longitudinal suture in the horizontal part of the palate bone is even more rare than the suture in the maxillary portion of the palate, which forms the lateral boundary of the medio-palatine bone. Six cases were found in the 1548 skulls: two with bilateral sutures and four with the suture on one side only. Three of the unilateral sutures are on the right side and the other on the left. The suture generally extends antero-laterally from the posterior edge to the transverse palatine suture within the region of the middle third of the horizontal part of the palate bone. The term "anterior" medio-palatine bones for the bones in the palatine processes of the maxillae and the term "posterior" medio-palatine bones for bones formed by the lateral longitudinal palatine sutures in the horizontal parts of the palate bones are suggested. The origin of both "anterior" and "posterior" medio-palatine bones may be due to extra centres of ossification.

Sex Differences in Pubic Bone.

S. L. WASHBURN (*American Journal of Physical Anthropology*, June, 1948) presents a more certain method of determining the sex of an individual skeleton based on the ischium-pubis index. The length of pubis and ischium was measured on 300 human skeletons of known race and sex. The ischium-pubis index was calculated. It averages 15% higher in females than males, and the sex of over 90% of skeletons can be determined by this index alone, provided major racial groups are treated separately. The size of the subpubic angle and many other characters which distinguish the female pelvis are dependent on the pubic bone. The sex difference in the sciatic notch belongs to an entirely different anatomical system. If it is combined with the ischium-pubis index, the sex of the vast majority of skeletons can be determined.

British Medical Association News.

MEETING OF THE FEDERAL COUNCIL.

A MEETING of the Federal Council of the British Medical Association in Australia was held at the Medical Society Hall, Albert Street, East Melbourne, on March 1, 2, 3 and 4, 1949, SIR HENRY NEWLAND, C.B.E., D.S.O., the President, in the chair.

Representatives.

The following representatives of the Branches were present:

New South Wales: Dr. W. F. Simmons, Dr. H. R. R. Grieve, Dr. A. J. Murray.
Queensland: Dr. A. E. Lee and Dr. H. W. Horn.
South Australia: Dr. L. R. Mallen, Dr. J. S. Verco.
Tasmania: Dr. T. Giblin, Dr. J. L. Grove.
Victoria: Dr. T. E. Victor Hurley, C.B., C.M.G., V.D., Dr. H. C. Colville, Dr. C. Byrne.
Western Australia: Dr. F. W. Carter, Dr. Leigh Cook.
 Dr. A. J. Collins, of New South Wales, who was unable to attend, had sent a proxy in favour of Dr. H. R. R. Grieve.

Minutes.

The minutes of the meetings of the Federal Council of August 12, 13, 14, 15 and 20, 1948, and of December 11, 12 and 13, 1948, which had been circulated among members, were taken as read and signed as correct.

Retirements from the Federal Council.

The General Secretary announced that Sir Henry Newland had retired from membership of the Federal Council as representing the South Australian Branch, and said that he had been a member of the Federal Committee and of the Federal Council from 1921 to December 31, 1948. He had been President of the Federal Committee since 1930, and had continued as President when that body had become the Federal Council. It was resolved that an appropriate minute should be drawn up expressing appreciation of the services to the Association and the profession of Sir Henry Newland during this period.

The General Secretary also announced that Dr. N. M. Cuthbert had retired from membership of the Federal Council as a representative of the Western Australian Branch. He had been a representative from 1941 to December 31, 1948. It was resolved that the Federal Council should place on record its appreciation of the services rendered to the Council by Dr. Cuthbert.

Election of Office Bearers.

Sir Henry Newland said that only one nomination had been received for the office of President, that of Dr. T. E. Victor Hurley. He congratulated Dr. Hurley on his appointment and vacated the chair in his favour. Dr. Hurley thanked the members for his election, and said that he appreciated their confidence. He could not bring to the office the wide experience of Sir Henry Newland, but he would do what lay in his power to further the welfare of the profession. He thought that a minute of appreciation of Sir Henry Newland should be drawn up by the Federal Council. This suggestion was seconded by Dr. W. F. Simmons and supported by Dr. F. W. Carter. Dr. H. R. R. Grieve also spoke in favour of it. Sir Henry Newland in his reply thanked those present for their appreciation of his services. He said that he had not clung to office, but that he had continued to serve while he thought he could do something useful for the profession during the important discussions that had taken place with the Government. When the Minister for Health had cut off negotiations with the profession, Sir Henry Newland had thought this a suitable time to seek relief from the burden of office. He thanked the members of the Council for their trust and for their friendship, and he made special mention of the splendid work carried out by the secretariat.

Later on in the course of the meeting the following minute was adopted by the Council:

The Federal Council of the British Medical Association in Australia at its meeting in Melbourne on March 1, 1949, wishes to place on record, on the occasion of his retirement as President, its appreciation of and its gratitude to Sir Henry Simpson Newland for his unceasing labours during many years of service. Coming to the Federal Committee as a representative of the South Australian Branch in 1921, Sir Henry Newland at once took a prominent

part in its deliberations and in 1930 was elected President. When in 1933 the Federal Committee became the Federal Council, Sir Henry continued in the office of President and has served with distinction since that time. During the difficult years of war his interest did not cease nor his energy falter. As a leader he has set a high standard and the Council knows that his influence will extend far into the future. He has the affectionate regard of every member.

The President, Dr. Victor Hurley, said that only one nomination had been received for the office of Vice-President, that of Dr. A. J. Collins, D.S.O., M.C. He declared Dr. Collins elected.

Only one nomination had been received for the office of Honorary Treasurer, that of Dr. W. F. Simmons, and Dr. Simmons was declared elected.

Reference was made to the fact that Dr. A. J. Collins had been unable to attend the meeting on account of the sudden illness of his son. It was resolved that the sympathy of the Council be extended to Dr. Collins, with best wishes for his son's speedy recovery.

Tenure of the Office of President.

Dr. H. R. R. Grieve said that he wished to move that the office of president should not be held by the same person for two years consecutively. He said that it was necessary that a motion of this kind should be entirely impersonal. It was the custom in the Branch Councils to share the responsibility of the president's office, and he thought that the same provision should obtain with the Federal Council. He thought that in all intraprofessional bodies the responsibility of president should be shared, and he referred to the suggestion that had been made in certain quarters that the policy of the Association was dominated by one of the larger Branches. The motion was seconded by Dr. A. J. Murray, who said that the presidency would circulate if the motion was adopted. Dr. H. C. Colville expressed his opposition to the motion, and gave his reasons. He said that where rotation such as was proposed was adopted, it was done for the sake of the individual, and not for the good of the council concerned. He knew of no body which had had its efficiency enhanced by this type of rotation. Rotation was adopted in order that the honour might be divided amongst different persons. In the Victorian Branch there was a president every year, but the Branch had a permanent chairman of council. Dr. Colville insisted that it had to be remembered that the Council's activities were continuous—they went on from year to year. He could not see by what process of argument the suggestion of an annual change of president could be sustained. The office should be held by someone recognized as a leader, an individual with prestige. Dr. Colville referred to Sir Henry Newland's enormous prestige, and to his eminence as a public figure. He held that it was not possible to elect a Federal Council of fifteen persons who were qualified for this office. After further discussion the motion was deferred till a later stage in the meeting. It was finally brought up again on the last day, and the Federal Council resolved to consider it at its next meeting.

The Secretariat.

The Federal Council had before it some applications from medical graduates for the position of Assistant General Secretary. After a short general discussion, it was resolved that the representatives of the New South Wales Branch, together with the General Secretary, should be constituted a committee to interview the applicants for the position, and that they should be given executive authority to make an appointment. It was resolved that the superannuation benefit to be granted to the Assistant General Secretary should be such as to secure to him at the age of sixty-five years an income of approximately £400 per annum.

The Federal Council appointed Miss H. Cope to act as an assistant to Miss Cameron.

Finance.

The financial statement and balance sheet of the Federal Council for the year ended June 30, 1948, was received and adopted. The financial statement for the six months ended December 31, 1948, was also received and adopted.

Dr. W. F. Simmons, the Honorary Treasurer, referred to a request that had been received from the Victorian Branch for a report on the future administration of the Federal Council. He said that the General Secretary had written to the Victorian Branch, asking the purpose for which it was suggested that a report should be made, and whether the Victorian Branch Council had any comments to make

on the administration. He also asked whether there were any aspects of the administration to which particular reference should be made. The Medical Secretary of the Victorian Branch had replied that the Honorary Treasurer of the Branch was in the habit of preparing a budget for each year's Branch expenditure, and one factor in such a budget was the anticipated expense concerning the Federal Council. The Victorian Branch understood that material changes were to be instituted in the secretariat of the Federal Council, and that the financial demands would be increased. It was thought that if the General Secretary of the Federal Council could report on the possible financial effect of the new factors, it would help the Branch Treasurer in the preparation of his budget. A statement on the administration of the Council was circulated amongst members. In this statement the expenses for the two half-years of 1948 were analysed and an attempt was made to estimate the expenditure for the coming year. The general conclusion was that during the next few years the administrative costs of the Council would be something in the neighbourhood of £6750 per year.

The Honorary Treasurer referred to the general organization fund and to the need for such a fund. Reference was made to this at a later stage in the meeting.

The Reservation of a Site for the Federal Council at Canberra.

At the meeting of the Federal Council in August, 1948, reference was made to a letter received in May, 1948, from the Surveyor-General and Chief Property Officer concerning the reservation of a site for the British Medical Association at Canberra. Correspondence had passed between the Federal Committee and the Federal Capital Commission in the years 1927 and 1928. It was pointed out at the meeting in August, 1948, that certain conditions attached to the granting of a lease at Canberra, and it was resolved that the matter should be left in the hands of the General Secretary, that he might obtain further information from the Commonwealth authorities. The General Secretary reported that he had written to Canberra in December, 1948, and on January 14, 1949, but that no reply had been received.

Medical Officers' Relief Fund (Federal).

Dr. W. F. Simmons, on behalf of the president of the Medical Officers' Relief Fund (Federal), presented an interim report for the half-year ended December 31, 1948. He discussed the five loans which were still outstanding, and explained that they were all good except one, which was a bad debt. The report was received.

Federal Medical War Relief Fund.

Dr. W. F. Simmons, on behalf of the president of the Federal Medical War Relief Fund, presented an interim report for the half-year ended December 31, 1948. He pointed out that the fund now amounted to more than £20,000, and that the trustees had been active in trying to find persons who were in need of relief and entitled to receive it from the fund. He pointed out that so far three claims for financial assistance had been made on the fund. The report was received, and it was resolved that the trustees should be asked to inform the local committees of management in the several States of the powers of the trustees to provide endowment policies for the children of deceased medical officers. It was pointed out that these powers were applicable to individual cases, and were not to be applied generally.

Dr. W. F. Simmons stated that the fund should have been closed in the previous week. He thought, however, that it might be advisable to extend the time to June 30, 1949, and that a final appeal for donations should be made. It was resolved that this should be done.

Decorations Received by Medical Practitioners.

The General Secretary reported that the congratulations of the Federal Council had been sent to Professor J. B. Cleland, C.B.E., and to Dr. E. A. H. Russell, O.B.E., on the decorations received by them from His Majesty the King.

All India Medical Conference.

The General Secretary reported that an invitation to send representatives had been received for the Silver Jubilee session of the All India Medical Conference, to be held at Calcutta in December, 1948. Unfortunately it had not been possible to find representatives to attend.

The Medical Association of South Africa.

The General Secretary reported that the 37th Congress (the 16th annual scientific meeting) of the Medical Association of South Africa was to be held at the University of

Capetown on September 19 to 24, 1949. Dr. F. W. F. Purcell, the Honorary Organizing Secretary, had written assuring a warm welcome to members of the Association from Australia who would be able to attend. The invitation had been conveyed to the Branches.

Australasian Medical Congress (British Medical Association).

Sixth Session

The General Secretary reported that the President had written to the President of the sixth session of the Australasian Medical Congress held at Perth on August 15 to 21, 1948, congratulating him on the success of the gathering.

The General Secretary read a recommendation from the Section of Naval and Military and Air Force Medicine and Surgery. With a slight verbal emendation the recommendation was adopted as follows:

Realizing that the maintenance of a medical service adequate to meet the defence and civil needs of Australia during World War II was the result of the efforts of the Central Medical Coordination Committee, this Section recommends to the Federal Council of the British Medical Association that this Committee should be reestablished under the Ministry of Defence with the object of planning for the defence and civil needs of Australia in the event of a national emergency.

It was resolved that the recommendation should be forwarded to the Minister for Defence.

A recommendation was also received from the Section of Medicine that rheumatic fever should be made a notifiable disease in the several States. The General Secretary explained that when this recommendation was referred to the Branches, the Victorian Branch had asked for a specific definition of what was meant by the term rheumatic fever. The Queensland, Tasmanian and South Australian Branches had approved of the recommendation, and the New South Wales Branch had expressed the view that rheumatic fever and its sequelae should be notified. In the discussion, the view was expressed that a branch of the Empire Rheumatism Council should be established in Australia. Dr. R. J. Verco said that there should be no difficulty in regard to the type of disease which should be notified. Acute rheumatism included acute rheumatic carditis, acute rheumatic arthritis and chorea. Dr. W. F. Simmons stated that the proposal had been brought before the National Health and Medical Research Council, and that that body had turned it down. Dr. A. J. Murray said that such an attitude was a defeatist attitude, and the answer of the National Health and Medical Research Council was the best argument that a move should be made by the Federal Council. After all, it was only suggested that the notification should be a "first step" towards the control of the disease. Dr. H. R. R. Grieve recalled the difficulty of diagnosis of scarlet fever and streptococcal sore throat, and he pointed out that a doctor had to give his honest opinion, and that he could not always be definite. If there was any doubt he would not make a notification. It was eventually decided that the sequelae should be included, and the recommendation of the Section of Medicine was adopted in the following form:

That it be a recommendation of the Section of Medicine through the Executive of the Congress to the Federal Council of the British Medical Association that rheumatic fever and its sequelae be made a notifiable disease throughout the Commonwealth as the first step towards the implementation of State programmes for the recognition and care of sufferers from this disease.

A recommendation was received from the Section of Public Health, Tuberculosis and Tropical Medicine. The recommendation, which was adopted, was as follows:

This Section requests the Executive of Congress to take steps to impress upon State and Federal Governments the urgency of the health aspects of the problem of the aborigines as presented by Dr. Cook.

The General Secretary said that some correspondence had passed between himself and the Honorary Treasurer of Congress, and that a financial statement would be sent at a later date.

Seventh Session.

Reference was made to the seventh session of the Australasian Medical Congress, which will be held at Brisbane at the end of May, 1950. The General Secretary said that the Queensland Branch had nominated as president of the congress Dr. Alexander Paterson Murphy, Professor of

Medicine in the University of Queensland. The Federal Council accepted the nomination.

The General Secretary reported that a request for a preliminary grant of £500 towards congress expenses had been made by the Executive Committee. The making of the grant was approved.

Eighth Session.

A request was received from the Victorian Branch that the eighth session of the Australasian Medical Congress (British Medical Association) should be held at Melbourne in 1952, as in that year the centenary of the Medical Society of Victoria would be celebrated. The invitation was accepted.

British Commonwealth Medical Conference.

Reference was made to the British Commonwealth Medical Conference, which was to be held at Saskatoon, Canada, on June 7 to 9, 1949. The preliminary discussions regarding this conference were held at London in September, 1948, when the Federal Council was represented by two delegates. A statement on that conference will be found in *THE MEDICAL JOURNAL OF AUSTRALIA* of November 27, 1948, at page 639. The General Secretary pointed out that an effort was being made to distribute the cost of the conference among the units of the British Commonwealth of Nations taking part in it. For the Saskatoon conference it had been decided that the expenses were to be distributed according to the subscription income of the several medical associations represented. This weighed rather heavily on the Australian Branches, who charged their members a high subscription rate. The result was that Australia, with a membership of approximately 6000, was to pay for one delegate a sum of £545 sterling. Dr. W. F. Simmons, as Treasurer, could not see that this was just. He thought that the amount paid should be assessed on a membership basis. He thought it unfair that Australia with a membership of 6000 should pay £545 sterling, and that Canada, with a membership of 9000, should pay only £289 sterling. Dr. A. E. Lee and Dr. R. J. Verco did not think that a membership basis would be a correct criterion, particularly in regard to India, where membership was large and income was small. Dr. C. Byrne asked whether the Federal Council was not the member represented at the conference, and the General Secretary replied that the Federal Council had no subscription income. It received from the Branches *per capita* payments. It was the Branches which received the subscription income. He went on to say that in his opinion the only proper basis on which expenses should be shared was on a membership basis. The President suggested that the delegate to the 1949 conference at Saskatoon should discuss this matter at the conference. A motion on these lines was drafted and carried.

It was resolved that the General Secretary, Dr. J. G. Hunter, should be the delegate to the conference at Saskatoon, and it was also decided that while he was in America he should visit the American Medical Association at Chicago and the Canadian Medical Association at Toronto. After further discussion it was also resolved that Dr. Hunter should go from Canada to England to attend the Annual Representative Meeting at Harrogate from June 29 to July 1, 1949. It was pointed out that he would be able to gather first-hand impressions of the working of the National Health Service in England, and that the information would be of use to the Federal Council and the Australian Branches.

The General Secretary reported that he had received a letter from the Medical Association of Elre, which had been represented at the British Commonwealth Medical Conference in September, 1948, advising that a copy of its journal, *Journal of the Medical Association of Elre*, would be sent every month, and asking that copies of *THE MEDICAL JOURNAL OF AUSTRALIA* should be sent to Elre in return. The General Secretary had communicated with the Editor of *THE MEDICAL JOURNAL OF AUSTRALIA*, and the exchange had been effected.

Organization of the Profession.

The General Secretary reported that he had paid a visit to the Western Australian Branch from January 23 to 30, 1949, and had addressed meetings in many centres. The visit had been paid at the request of the Western Australian Branch, and the General Secretary thought that it had been useful.

Special Groups.

The General Secretary reported that he had received a communication from Dr. R. F. Watson, president of the Section of Clinical Pathology of the Victorian Branch, inquiring into the procedure to be adopted in the formation of an Association of Clinical Pathologists within the ambit of the British Medical Association. The information had been given to Dr. Watson.

The General Secretary also reported that he had received a request from the Ophthalmological Society of Australia (British Medical Association), asking that Dr. A. J. Collins and Dr. Mervyn Archdall, while they were in England, should investigate (a) the relations of the Ophthalmological Society to the optician under the National Health Scheme in Great Britain, and (b) the attitude of the British Medical Association in England to medical auxiliaries and the nature of auxiliaries approved by the British Medical Association. The General Secretary reported that copies of the relevant National Health Service (Supplementary Ophthalmic Services) Regulations had been secured and sent to the Ophthalmological Society of Australia.

A discussion took place in regard to bodies which were outside the ambit of the British Medical Association. The Victorian Branch had asked that steps should be taken to negotiate with these bodies with a view to their being brought within the ambit of the Association. A motion that steps should be taken in this regard was moved and adopted.

A request was received from the Oto-Rhino-Laryngological Society of New South Wales, asking that approval should be given to the formation of a group, to be known as the Oto-Rhino-Laryngological Society of Australia (British Medical Association). Approval was given.

The General Secretary read a letter from Dr. A. Distin Morgan, of the Section of Anaesthesia of the New South Wales Branch, in regard to the constitution of the Australian Society of Anaesthetists, which was a special group of the British Medical Association in Australia. This constitution had been adopted at a meeting of the Australian Society of Anaesthetists at Perth in August, 1948. The General Secretary said that the constitution had not been submitted to him. The New South Wales Section pointed out that the new constitution overrode that of the Section. According to this constitution, the representative of a State on the council of the Australian Society of Anaesthetists would act as chairman at meetings of the State section, and of the sum received annually in subscriptions from each State a proportion should be returned by the treasurer of the Federal body to the treasurer of the State sections in question. The General Secretary said that it had never been intended that the Federal organization should take over the State organization. He had written to Dr. Geoffrey Kaye, the honorary secretary of the Australian Society of Anaesthetists, and had received a reply, in which Dr. Kaye asked for the guidance of the Federal Council. Dr. H. R. R. Grieve said that the constitution was the reverse of a democratic constitution. It set up an oligarchy, and it was certainly not in the interests of State membership. The build-up should be from the bottom. After discussion it was resolved that a copy of the constitution of the Federal Council should be sent to the Australian Society of Anaesthetists.

The Australasian Association of Psychiatrists.

The General Secretary reported that he had received a communication from the Australasian Association of Psychiatrists, in which it was stated that it would be the future policy of the association to consult the British Medical Association before it took any medico-political action.

Australian Post-Graduate Federation in Medicine.

The General Secretary announced that he had received from Dr. V. M. Coppleson, honorary secretary, a copy of the constitution of the Australian Post-Graduate Federation in Medicine. Copies had been forwarded to the Branch Councils and to the members of the Federal Council.

Commonwealth Council for National Fitness.

The General Secretary stated that he had received the report of the Commonwealth Council for National Fitness for 1947. The report was formally received.

National Health and Medical Research Council.

Twenty-Fifth Session.

At its previous meeting in August, 1948, the Federal Council when considering the report of the twenty-fifth session of the National Health and Medical Research Council, decided to request Dr. W. F. Simmons, its representative on that body, to obtain clarification of the term "public health authorities" used in a resolution of the National Health and Medical Research Council dealing with the subject of tuberculosis. This resolution provided that the States should be asked to introduce legislation to make notification of tuberculosis compulsory on "reasonable evidence". It also provided that on the notification form two questions should be asked. The first was whether the patient was to be visited by "public health authorities," and the second was to the effect that if the practitioner was to be responsible

for the care of the patient, whether he would be prepared to send a six-monthly progress report to the "public health authorities". The General Secretary stated that Dr. Simmons had received a letter from Dr. A. J. Metcalfe, chairman of the National Health and Medical Research Council, in which the words "public health authorities" were defined as "a medical officer of health or a member of his staff who has been authorized to act for him".

The General Secretary stated that he had received the official report of the twenty-fifth session of the National Health and Medical Research Council, which was held at Canberra on May 18 and 19, 1948.

Twenty-Sixth Session.

The Council had before it a report of Dr. W. F. Simmons on the twenty-sixth session of the National Health and Medical Research Council held at Sydney on November 17 and 18, 1948. Included with this document was a condensed report of a meeting of the Medical Research Advisory Committee, which had been held prior to the meetings of the council. Both reports were received.

The General Secretary referred to a letter that had been received by Dr. W. F. Simmons from the chairman of the National Health and Medical Research Council in regard to a letter from Dr. C. E. Cook, Commissioner for Public Health in Western Australia. This letter dealt with precautions that might be taken by the tinting of local anaesthetic solutions, in order to prevent the administration of the wrong type of solution for various procedures. The opinions of the Australian Society of Anaesthetists and of the Oto-Rhino-Laryngological Society of New South Wales had been obtained and had been sent on to the National Health and Medical Research Council by Dr. Simmons.

Publicity.

The Federal Council resolved that Dr. W. F. Simmons, Dr. A. J. Collins, Dr. H. R. R. Grieve and Dr. H. C. Colville should be reappointed members of the Publicity Committee.

Dr. C. Byrne asked what had been done by the Publicity Committee in recent months. Dr. H. R. R. Grieve referred to Press statements that had been produced, and pointed out that the difficulties of procuring the publication of these statements were considerable. The General Secretary referred to what he called organized and unorganized publicity. It was not easy to develop organized publicity. The Tasmanian Branch, for example, had suggested that a statement on a national health service and similar matters should be sent to every household in the Commonwealth. The General Secretary said that this was all very well, but that even if such a piece of work could be completed, the cost would run into many thousands of pounds. He thought that doctors had to be their own publicity agents.

Dr. F. W. Carter said that repeated requests were received in Western Australia for general publicity and it was also pointed out that in Western Australia the delay associated with the receipt of statements for publication was apt to detract from the usefulness of the statements. After discussion the Federal Council approved of the spending of money for the purpose of telegraphing to the various Branches as required statements for insertion in the local Press. It also approved of the spending of money for the preparation of statements to be circulated through the Branches to the local members and to members for use in talks with patients.

A letter was received from the Victorian Branch, requesting that THE MEDICAL JOURNAL OF AUSTRALIA should publish each week a supplement on medico-political matters. The Editor of THE MEDICAL JOURNAL OF AUSTRALIA, on being invited to speak, said that it would be possible for a supplement to be issued, but that there would be certain difficulties associated with such a procedure. A supplement had to be sent with every copy of the journal and it had to be a document complete in itself. It was likely that the publication of a supplement would involve an increase in expenditure, and possibly of editorial staff. A supplement would be produced from material supplied by the secretariat of the Federal Council. At the present time adequate facilities existed for the publication of any medico-political news which the Federal Council or the Branches cared to submit. News of this kind was always published in the same part of the journal, under the heading of "British Medical Association News", and readers knew where to look for it. The Editor was doubtful whether sufficient material would be forthcoming for the production of a weekly supplement and he thought that the Federal Council and the Branches might make more use than they did of the present available facilities. The Federal Council resolved that the Publicity Committee should be requested to approach the Editor of THE MEDICAL JOURNAL OF AUSTRALIA for the publication of as much medico-political news as possible.

The Pharmaceutical Benefits Act.

The General Secretary reported that he had received from Dr. A. J. Metcalfe, Director-General of Health, a letter dated January 21, 1949, in which it was stated that the Minister intended to appoint as soon as practicable six persons to the Formulary Committee. The Act provided that three of the six persons should be practising medical practitioners, and that one should, if available, be a pharmacologist. The Federal Council was invited to submit from its membership a panel of twelve names, from which the Minister would select three practitioners for appointment to the committee. The Director-General also asked for the Federal Council's nomination for the position of pharmacologist. The Federal Council discussed the matter and decided that it could not accede to the Director-General's request.

Reference was made to Press statements regarding regulations in connexion with the Act which had been forecast by the Prime Minister, and which would make it an offence for a doctor to prescribe any medicines contained in the Government formulary other than on a Government form. The Federal Council determined to test the legality of these regulations and in the meantime to stand behind any member who might be prosecuted under them.

The President was authorized to take whatever steps were necessary to test the legality of the proposed regulations under the Act. The Federal Council determined that the following Press statements should be issued:

Pharmaceutical Benefits Act, 1947.

The Government has now declared its intention. It will readily and vindictively prosecute doctors who stand for their freedom and the freedom of their patients. It will exercise its legal powers to make such prosecutions possible.

The Government has repeatedly stated that it could not and would not compel doctors to prescribe medicines from the Government list—it now reverses that policy. It now proposes to force doctors to sign prescriptions which happen to be within the Government list on Government forms. This is plainly an attempt at coercion.

The British Medical Association has received certain legal advice on the Government's powers of compulsion under the Pharmaceutical Benefits Act. Its members will not yield to coercion, nor indeed to any limitation of their own or their patients' freedom. It will take all necessary steps, including legal action, to preserve its freedom.

The British Medical Association wishes to repeat to the people that if the Government were genuine in its desire to give them these medicines free, it could easily do so by paying for them on presentation of a doctor's prescription.

National Health Service.

The Federal Council considered the resolutions adopted at its meeting of December 11 to 13, 1948, defining its policy. The General Secretary said that these resolutions had been sent to the branches and certain proposals had been made. The Federal Council resolved that the following preamble should be inserted before the resolutions adopted at the December meeting:

That the following preamble be inserted before the resolutions concerning control, adopted by the Federal Council at its meeting on December 11, 1948, viz:

That essential points of any National Health Service are:

(i) That payment be by the refund system exclusively.

(ii) That there should be a scale of benefits and not a schedule of fees.

(iii) That there be no experimental health centres, as envisaged by the Minister for Health under the National Health Service Act, 1948.

In the event of those three points not being met by the Government and a form of control becoming unavoidable, then the following form of control should be advocated:

(i) That, under the Minister and at a level with the Director-General of Health, there shall be a controlling body, predominantly medical and representative of the practising profession. Its function will be the control of all the professional aspects of the National Health Service.

(ii) That no regulations under the National Health Service Act be promulgated without being first approved by the controlling body.

(iii) That the Department of Health shall have no function under the National Health Service Act, other than the implementation of policy arrived at by the controlling body.

(iv) That medical members of the controlling body should be employed part-time and paid on a sessional basis.

(v) That medical representatives of the practising profession on the controlling body should be the direct nominees of the medical profession.

(vi) That the representatives of the practising profession should be appointed for a period of three years and be eligible for re-nomination.

The General Secretary referred to the reply from the Minister to the Federal Council's letter of December 13, 1948. This reply was published in THE MEDICAL JOURNAL OF AUSTRALIA of February 5, 1949, at page 162. After discussion, it was resolved that a further letter should be sent, and on this occasion to the Prime Minister. The letter was as follows:

135, Macquarie Street,
Sydney.

3rd March, 1949.

The Right Honourable J. B. Chifley, P.C., M.H.R.,
Prime Minister of Australia,
Canberra, A.C.T.

My Dear Mr. Prime Minister,

THE Federal Council of the British Medical Association in Australia wholeheartedly endorses the policy of the Government to assist the people in meeting the costs of medical care.

It is therefore to be deprecated that the objections of the medical profession to the associated principles in this policy have been summarily rejected by the Government, in spite of the determined emphasis which has been placed upon them by this Council in its conferences with the Minister for Health and Social Services.

We desire again to inform the Government that the profession is inflexible in its determination to resist the following facets of the proposed Health Service:

(1) Subjection of doctors to the Department of Health through the power of regulations, in the framing of which they can have no voice.

(2) Intrusion by the Department into the confidential relationship between doctor and patient.

(3) The establishment of a contract or arrangement with individual doctors which denies them the right of practice outside the Government scheme. As many doctors would refuse to enter into such an arrangement their patients would be deprived of their fundamental right to choose their own doctor without thereby forfeiting their right to medical benefits.

(4) The imposition of burdensome clerical work which would absorb valuable time otherwise available for attention to patients and which in an alternative scheme would not be required.

(5) The establishment of Government-controlled experimental health centres which would replace private doctors by Government-employed doctors.

It is clear that these provisions bear no essential relation to the principle of payment by the Government for medical services to the people and their immediate effect must be to place the profession under the control of the Government. Furthermore, they stem entirely from the desire of the Government for economic and other reasons to make payments directly to doctors.

This Council, therefore, in a final attempt to ensure the fulfilment of an important purpose of the Act, which is the provision of financial assistance to meet the cost of medical care, again respectfully suggests that provision be made for direct payment to patients in accordance with a scale of benefits, thus leaving to the medical profession its traditional freedom to practise its calling unhampered.

If the Government rejects this request, then it alone will be responsible for denying to the people a service they require and for which, moreover, they have already paid.

Furthermore, the Federal Council, with what it believes to be strong public approval, feels that urgent priority over all other measures of public health should be given through immediate Government action to the following items of the positive health policy of

the Council communicated to the Government in 1947, none of which has yet been the object of effective action:

(1) A comprehensive plan for the prevention of disease, including large scale planning of popular medical education by press, radio and other means and the adoption of nation-wide means of immunization against disease.

(2) Large scale increase in hospital accommodation and equipment.

(3) The provision of greatly increased sums for medical research.

(4) Decentralized facilities for diagnosis.

(5) A large scale extension of the Flying Doctor Service under its present efficient management.

(6) The provision of a non-hospital service for old age and invalid pensioners and citizens registered for unemployment benefits over a long period.

Faithfully yours,

(Signed) VICTOR HURLEY,
President.

The Federal Council discussed the nature of the information which should be sent on to the Branch Councils, and it was decided that the Branch Councils should be asked to inform their members of the policy of the Federal Council in regard to the conditions which should obtain in a fee-for-service scheme of Government medical benefits. The Federal Council also decided to ask Branch Councils to advise their members not to cooperate in any fee-for-service scheme of Government medical benefits which was contrary to the policy of the Federal Council, and to refrain from replying or responding to any approach by the Government to them as individuals, unless they had previously obtained the consent of the Branch Councils.

The legal aspect of the subject was discussed, and the Federal Council decided that Branch Councils should be informed that the Federal Council would oppose any attempt by the Government to implement, by coercion of medical practitioners, any form of medical service which was contrary to the policy of the Council.

An Independence Fund.

Dr. Leigh Cook raised the question of the establishment of an independence fund to meet the conditions which were likely to arise in connexion with the Government's effort to introduce its national health proposals. He wondered whether this could be done by an increase in Branch subscriptions. Dr. W. F. Simmons said that the Federal Council had already taken some action at its August meeting, and he thought that any proposal to deal with the matter through Branch subscriptions was to advocate a slow method. The present case was a case of "do it now". He was of the opinion that the voluntary method would have to be used. The Federal Council resolved that a Federal Independence Fund should be launched forthwith, that it should be fed by moneys received by Branch Councils from members, (a) by an immediate appeal for voluntary subscriptions, (b) by an increase in the annual subscription for 1949. The following were appointed trustees of the Federal Council Independence Fund: Dr. W. F. Simmons, Dr. A. J. Collins, Dr. H. R. R. Grieve, Dr. A. J. Murray and Dr. J. G. Hunter. The General Secretary was authorized to consult the association's legal advisers in regard to the fund and it was also determined that the Federal Council should be empowered to wind up the Independence Fund at its discretion, and to refund to subscribers, on a *per capita* basis according to amount of subscription, any unexpended portion of the fund.

Administration of a National Health Service.

The General Secretary stated that he had received from the Western Australian Branch a scheme of administration of a national health service and it was decided that this should be sent to the other Branches for their consideration.

Press Statements.

It was resolved that the following paragraph should be added to the Press statement issued in connexion with the *Pharmaceutical Benefits Act*:

The National Health Service Act.

The Federal Council has written to the Prime Minister an important letter concerning its relations with the Government over the provisions of the above Act.

A statement for the Press, which had been drafted by Dr. H. C. Colville, was approved. The statement is as follows:

**FEDERAL COUNCIL OF THE BRITISH MEDICAL ASSOCIATION
IN AUSTRALIA.**

National Health Service.

Government proposal to pay one-half of all medical expenses incurred by members of the public.

The Council wishes to place the following facts clearly before the public:

The medical profession has not the slightest objection to the Government paying one-half of all medical expenses incurred by members of the public. It offers to cooperate in the process by providing all patients with receipts for fees paid, detailing the services for which those fees have been charged. These detailed receipts would constitute the basis for all claims by patients for the Government benefit.

Any involvement of the medical profession in the Government's proposal should begin and end at this point.

The Government, on the other hand, seeks to involve the medical profession in the proposal in the following ways:

1. The Government insists that the whole of the clerical and other work involved in securing the Government benefit for members of the public shall be carried out by the medical profession. This would involve every doctor in an enormous amount of additional work, from which he would not only receive no compensating advantage, but which would place him in the position of depending for one-half of his income on the attitude towards him of Health Department officials.
2. The Government demands the right to fix the fees for all private medical services throughout the Commonwealth, a form of price-fixing which it has abandoned in the case of every other section of the community.

The medical profession, in its own interests, refuses to accept either of these proposals.

3. The Government demands that doctors shall keep records of the medical history of all patients, such records to be made available, on demand, to Government officials as part of the machinery for enabling patients to obtain medical benefits.
4. The Government insists that it shall be a condition for any patient to obtain medical benefits, that his doctor shall have entered into an agreement with the Government to confine himself exclusively to practice under the Government scheme. As many doctors would undoubtedly refuse to enter into such an agreement, their patients would be deprived of their fundamental right to choose their own doctor without thereby forfeiting their right to medical benefits.

The medical profession refuses in the public interest to accept either of these proposals.

The offer of the medical profession to cooperate in the National Health Service, under terms which it considers fair and reasonable, still stands and it is hoped that the Government may yet see fit to alter its decision on the matter, thus ensuring that the public will receive medical benefits in a manner satisfactory to all concerned.

(Dr.) J. G. HUNTER,
General Secretary.

4th March, 1949.

The Medical Journal of Australia.

The Federal Council expressed its appreciation of the issue of THE MEDICAL JOURNAL OF AUSTRALIA for February 5, 1949, which dealt almost exclusively with the *National Health Services Act*.

Hospital Services.

At its meeting in December, 1948, it was resolved by the Federal Council that the Branches should be requested to define their views in regard to public hospital policy, with particular reference to the following matters: (a) abolition of the honorary system, (b) the remuneration of visiting medical staffs, (c) the establishment of private and intermediate wards in public hospitals. The Tasmanian Branch had replied that it thought the honorary system should be

abolished. It held that remuneration for visiting medical staff should be five guineas for a three-hour session and it approved of the establishment of private and intermediate wards. The South Australian Branch had replied that the time was not opportune to express an opinion in regard to the honorary system. It held that the honorary system was outmoded, and should be replaced by a paid service at a time to be decided on by the Federal Council. It held that the sum of five guineas should be paid for a three-hour session, and it agreed with the establishment of private and intermediate hospital wards. The Victorian Branch said that it was impossible to give a general opinion in regard to the honorary system, on account of the differences in country hospitals and the teaching hospitals. It agreed with the establishment of private and intermediate wards. The Western Australian Branch said that it was advisable to continue the honorary system at the present time, especially in view of the Government threat. It did not approve of payment of visiting staffs on a sessional basis, but held that all payments should be on a fee-for-service basis. If payment was to be made on a sessional basis, that payment should not be a concessional one. The New South Wales Branch approved of the continuation of the honorary system. If the payment of visiting medical officers became inevitable, then payment should be made on a sessional basis at a rate of not less than three guineas for the first hour and an additional guinea for each succeeding hour or part thereof. It also held that public hospitals should be open to and provide accommodation for all classes of patients—public bed, intermediate and private according to their means—and that intermediate and private patients should pay for medical attention. It also held that all reputable medical practitioners should be entitled to render services to intermediate or private patients in all hospitals except teaching hospitals.

Dr. H. R. R. Grieve said that Dr. Collins had asked him to present his views. Dr. Collins held that this was a complex question and that allowance had to be made for the differences of conditions in the different States. A decision had to be flexible, so that it could be applied in different States and the teaching hospitals complicated the problem. There was no doubt that teaching hospitals were different from other types of hospital. Dr. Collins thought that there should be no attempt to set up a uniform policy, but that the question should be referred to Branch Councils, which would set up special committees comprising persons skilled in hospital administration and practice. In this way a report on the hospital services in each State would be obtained. The President remarked that discussions were taking place in Victoria in regard to the relationship between the teaching hospitals and the University. Dr. A. E. Lee said that it was necessary not to lose sight of the reason why the matter was before the Federal Council. It was because hospital practice was concerned in the Government proposal. He thought that the conclusion had to be reached on a Federal basis and that in the views that were expressed in the different States there was an element of shelving. Dr. R. J. Verco agreed with the New South Wales suggestion. The problem was simpler now than it would be in years to come. At the present time hospital accommodation was scarce, but a time might come when it would be plentiful, and then it would be necessary to deal with closed institutions, with closed intermediate beds and closed private beds. Dr. L. R. Mallen said that the problem affected not only the metropolitan but also country areas. In the country there were public hospital beds and honorary service was being given. He thought that each State knew its own situation. Dr. Leigh Cook said that it would be regrettable if the Federal Council were to discuss the matter with the States separately. The type of committee which had been envisaged in New South Wales and Victoria had been in existence in Western Australia for some time. This committee reported to the Branch Council. In this matter the Federal Government was active and it should deal only with the Federal Council. Dr. W. F. Simmons was glad to know that in this matter New South Wales and Victoria thought alike. The matter was one of current policy, and should be dealt with by the Federal Council. Dr. T. Giblin wished to associate himself with the remarks of Dr. Leigh Cook and Dr. Simmons. There was a danger of deferring the matter indefinitely. Some of the smaller States had become more "advanced" and were not prepared to refuse hospital admission to patients, even if they could afford to pay. It was necessary to have a sound policy and to give a lead. This would help conditions in Tasmania. Dr. F. W. Carter referred to private and intermediate wards, and said that smaller hospitals were slowly and surely closing up. It had become an urgent matter to press for an increase in the number of intermediate and private beds. Dr. H. R. R. Grieve spoke on the advisability of the setting up of special committees by the Branches to inquire into hospital services.

In this he was supported by Dr. A. J. Murray. Dr. H. C. Colville thought that the Federal Council had sufficient material at the present time to lay down a policy. Dr. H. R. R. Grieve disagreed, and said that a wider consideration of the whole problem was needed. Dr. H. W. Horn referred to the inadvisability of a policy of postponement. Dr. A. E. Lee expressed the view that where public hospitals were available to all members of the community and the financial responsibility for them was accepted by the State, there was no need for the continuance of an honorary system. To this Dr. Grieve objected, and said that the acceptance of such a view was a policy of surrender. Dr. T. Giblin replied that if the view did indicate a surrender, the surrender had begun years before in connexion with medical services for the Repatriation Department.

The Federal Council finally determined, on the motion of Dr. H. C. Colville, that Branch Councils should be informed that it was the opinion of the Federal Council that, where public hospitals were available free to all members of the community, and the whole financial responsibility for their upkeep had been accepted by the Government, no reason existed for the continuation of the honorary system.

In regard to types of hospital beds, and their availability to medical practitioners, the Federal Council expressed the opinion that public hospitals should be open to and provide accommodation for all classes of patients—public bed, intermediate and private according to their means—and that intermediate and private patients should pay for medical attention. It stated that all medical practitioners should be entitled to render services to intermediate or private patients in all public hospitals, and resolved that Branch Councils should be asked to implement this policy. The Federal Council determined that consideration of the question of the amount of remuneration for visiting medical staff should be deferred. At the same time it adopted a resolution stating that in principle a sessional service should not be taken as a basis for future negotiations with the Government. Unless impracticable, it was considered that all methods of payment should be on a fee-for-service basis. Where the service had to be on a sessional basis for any adequate reason, the fee should not be a concessional one.

The Federal Council also resolved that Branch Councils should be recommended to set up promptly committees composed of authorities on hospital administration and policy, whether members of Branch Councils or not, to report on the desirable elements of a British Medical Association policy for all classes of hospitals, and that Branch Councils be asked to make such reports available to the Federal Council. The drawing up of terms of reference for these committees was left in the hands of the President, the Vice-President and the General Secretary.

The Tasmanian Branch had forwarded a letter from the Tasmanian Minister for Health in regard to payment of medical practitioners for attending midwifery patients in public hospitals. The Federal Council adopted a resolution disapproving of the fixing of an inclusive fee to cover all cases of midwifery or other procedures, irrespective of the complications which might arise. The Federal Council also resolved that it did not approve the system of payment proposed by the Tasmanian Minister for Health, which was tantamount in principle to that adopted by the Federal Government in its *National Health Service Act, 1948*.

The General Secretary said that a letter had been received from the secretary of the Royal Australasian College of Physicians, expressing the view that the system by which medical patients were treated by qualified physicians specially appointed to the staff for that purpose should be maintained. The executive of the College passed this opinion on two grounds. The first was the desirability of securing for patients suffering from internal diseases the best possible specialist treatment, and the second was the desirability for the maintenance of an efficient and highly qualified staff for such hospitals as might in the future become clinical medical schools. The College of Physicians asked that this resolution should be sent to the Tasmanian Branch. The Federal Council discussed the matter, and approved of the recommendation of the Royal Australasian College of Physicians. It decided to send the recommendation on to the Tasmanian Branch.

Policy of the American Medical Association in Regard to Medical Care.

The General Secretary drew attention to the policy of the American Medical Association in regard to medical care, which had been published in *The Journal of the American Medical Association* of December 11, 1948, at page 1099. He reported that copies had been sent to the Branches and to the members of the Federal Council.

World Medical Association.

The General Secretary announced that he had completed *questionnaires* from the World Medical Association on secret remedies and appliances, on unqualified medical practice and on post-graduate medical education and specialized training. An addendum in connexion with the last mentioned was nearing completion.

In regard to the second annual meeting of the association held at Geneva on September 8 to 11, 1948, the General Secretary said that reports had been received from the two delegates of the Federal Council, Dr. A. J. Collins and Dr. Mervyn Archdall.

The General Secretary stated that he had received from the Secretary-General of the World Medical Association a number of documents. These dealt with questions discussed at the September meeting at Geneva. They were mentioned in an editorial in this journal on November 20, 1948. One of the questions which was asked by the Secretary-General had to do with the publication of reports by the World Medical Association. Three suggestions had been made in regard to this. The first was that reports should be purely factual. The second was that opinions and recommendations should be made as the result of the factual information on non-controversial subjects. The third was that reports should be made on controversial subjects as well, according to the majority opinion. It was thought that minority opinions might also be recorded. The Secretary-General thought that reports under the first heading would be issued by himself, that reports under the second heading would be issued by himself after approval of the Council had been obtained, and that reports under the third heading would be issued only under the direction of the General Assembly. The General Secretary of the Federal Council said that he had referred this question to the Branches. The Victorian Branch was the only Branch which thought that reports should be limited to purely factual statements. After discussion the Federal Council decided that all three proposals of the World Medical Association regarding publication of the results of its investigations should be approved.

Reference was also made to the problem of the settlement of refugee physicians. The Secretary-General had pointed out that the great majority of countries had an adequate number of physicians, and local laws regarding citizenship and medical education prevented the absorption of any great number of refugee physicians. However, the General Assembly of the World Medical Association had directed the Council to go into the problem as fully as possible. It had also directed the Council to do all in its power in cooperation and contact with member associations to help in the solution of the problem. The Secretary-General had stated that the office of the World Medical Association would appreciate any suggestions which might be made towards a satisfactory solution. The Federal Council discussed the matter and decided that the question of placing refugee physicians should be left in the hands of the countries concerned. The Federal Council also resolved that the World Medical Association should be informed that the Federal Council was of the opinion that, in view of the number of registered medical practitioners in Australia and the number of medical students, the density of the medical population of Australia would be so increased during the next decade as to make any increase above the normal average of entrants unabsorbable.

A communication was received from the Victorian Branch, asking that the question of the continued membership of the World Medical Association should be considered. After a motion in accordance with the Victorian Branch's letter had been moved by Dr. C. Byrne, the Federal Council discussed the matter and decided to continue its membership. The Council also resolved that the appointment of delegates and alternate delegates and observers to the 1949 General Assembly of the World Medical Association should be left in the hands of the President and General Secretary.

Contract Practice.

Contract Practice Committee.

A letter was received from the Western Australian Branch, asking that when it was dealing with a contract practice matter, the Federal Council should have before it a report from the Contract Practice Committee. The General Secretary said that he had referred this letter to the Branches. The Tasmanian Branch had replied that in its opinion the expense of such an innovation was not warranted. The Queensland Branch thought that the question of the expense involved should be referred to the Branches. The Victorian Branch thought that the Federal Council did not require the help of such a committee, and was quite able to make its own decisions. The South Australian Branch

was in favour of the revival of the activities of the Contract Practice Committee. The New South Wales Branch thought that the proposal was unnecessary. Dr. Leigh Cook thought that possibly the Western Australian Branch had not made itself clear. It was not necessary that a contract practice committee as now constituted should function. A contract practice committee could be formed from members of the Federal Council. He thought that contract practice questions were often rushed through the Council, and as a matter of fact, during the meeting held in Perth he had been aghast at what he described as the scant consideration given to contract practice matters. The Contract Practice Committee could meet a day earlier than the Federal Council. Dr. A. E. Lee thought that other work of the Federal Council could be done by committees. In fact, the Federal Council could break up into committees. Dr. W. F. Simmons pointed out that committees would not have all the necessary information, and he asked who would act as recorders for these committees. Dr. C. Byrne saw difficulty in the suggestion. After further discussion the Federal Council resolved to refer to the Branches for their consideration the question of the appointment of a contract practice committee of members of the Federal Council, which should, immediately prior to meetings of the Council, consider and make recommendations on matters on the agenda relating to contract practice which were referred to it by the Council. The Federal Council resolved that the former Contract Practice Committee of the Federal Council should not be reappointed. It also resolved to extend to the former Contract Practice Committee the thanks of the Federal Council for the services rendered by its members.

Provision of Contract Practice for People with Incomes Above Those Laid Down in the Federal Common Form of Agreement.

At its meeting in August, 1948, the Federal Council decided that the whole matter of contract practice for people with incomes over those mentioned in the common form of agreement should be referred to the Branches, and that at the next meeting the views of the Branches should be considered. The General Secretary reported that some divergences of opinion existed among the Branches. Dr. R. J. Verco expressed the opinion that the needs of the people concerned could well be met by the mutual health insurance societies which already existed. After discussion the Federal Council resolved that it was desirable that the provision of a medical service within the scope of the common form of agreement plus immunization for people in the upper income limit should be left in the hands of the mutual health insurance societies.

Medical Examination for Pilots' Licences for Aircraft.

At its meeting in August, 1948, the Federal Council dealt with the fees payable for the medical examination of pilots applying for licences for aircraft. At that meeting the General Secretary stated that he had received a reply to a letter from the Federal Council from the Director-General of Civil Aviation, who had agreed that there should be some upward revision of fees. The proposal was that the fee should be the same for all examinations (one and a half guineas) with certain exceptions. It was resolved that a decision on the matter should be deferred until new forms which were to be introduced had been received. The General Secretary said that these forms had arrived and had been sent to the Branches. The Branches had been asked their views on the fees which should be payable. The consensus of opinion among the Branches was that a fee of not less than two guineas should be paid. The Council therefore resolved that the fee for medical examination for pilots' licences for aircraft should be two guineas for the initial examination and one and a half guineas for reexamination.

Fee for Examination for Entry into the Royal Australian Navy.

At its meeting in August, 1948, the Federal Council considered the fee for examination of entrants into the Royal Australian Navy, and a resolution was adopted to the effect that the fee should be one and a half guineas. The General Secretary reported that he had written to the Department of the Navy in the matter on two occasions, and had received no reply. He was still waiting.

Fees for Life Assurance Examinations.

A letter was received from the Western Australian Branch, requesting that members should be informed that the fee for a report with examination for life assurance should be two guineas. The General Secretary said that he had received a letter from the Life Offices Association, stating

that the fee had been fixed at £1 7s. 6d. in New Zealand, and that member offices in Australia were prepared to pay a similar fee as from February 1, 1949. The matter had been referred to the Branches, and they had agreed that the fee should be two guineas. The Federal Council resolved that the fee for examination for life assurance requiring the use of the extended form should be two guineas. The Federal Council also decided to inform the Life Offices Association for Australasia that it was the intention of the British Medical Association to inform its members that the fee for this examination would be two guineas as from June 30, 1949.

Unemployment and Sickness Benefits Act, 1944.

At previous meetings of the Federal Council, the *Unemployment and Sickness Benefits Act, 1944*, had been discussed and exception had been taken to the request by the Department of Social Services for disclosure of information about patients when the consent of the person concerned had not previously been obtained. At the meeting in August, 1948, the General Secretary reported that the Director-General of Social Services had stated in a letter that instructions would be issued that requests for information should be made by letter setting out the whole of the circumstances and explaining the reason. Departmental officers would also be advised that when a doctor expressed a wish to that effect, the claimant's authority should first be obtained. If the requirement of a written authority was to become the rule rather than the exception, it seemed that claimants would have to be held responsible for obtaining from doctors the information required by law to support an application for arrears. The Director-General also stated that when a special examination and report were required by his department, payment of the usual fee would be authorized. In most cases, however, officers of the department were acting merely on behalf of the claimant, whose responsibility it was to furnish medical evidence in support of his claim for benefit. In such cases, the Director-General held, it would not be possible to authorize payment to a medical practitioner. The General Secretary reported that the matter had again been discussed by the Branches. In their replies some Branches pointed out that the Department would often possess the information required, but that this would not always be so, and that the department would require confirmation in certain cases. After discussion the Federal Council resolved to reaffirm its previous decision that no information should be furnished without the patient's written consent. It also resolved that when the information required by the Department of Social Services was simply the date on which incapacity commenced no fee should be charged. When, however, a report was required by the Department of Social Services, the Council reaffirmed its policy that a fee of 10s. should be paid.

The Salaries of State Medical Officers.

At its meeting in August, 1948, the Federal Council dealt with the salaries paid to State Government medical officers. It did this at the instance of the Western Australian Branch, and resolved that the salaries of those employed in full-time service should be reviewed and referred to the Branches for consideration. The General Secretary reported that he had received a further communication from the Western Australian Branch, drawing attention to certain anomalies in advertisements for medical officers inserted in the lay Press by various Commonwealth departments. The General Secretary reported that he had received several replies from the Branches, a number of which stated that the remuneration offered to State Government medical officers should be not less than that paid by the Commonwealth Department of Health. During discussion on this subject a reference was made again to the amount of salary paid to a tuberculosis officer of the Department of Health in Victoria. The Federal Council also had a copy of a letter received by the South Australian Branch from the State Committee of the Australasian Association of Psychiatrists in regard to the salaries of psychiatrists in State mental institutions. The result of the discussion on these subjects was a series of resolutions. First of all the Federal Council resolved that a base rate be determined by the Federal Council for salaried medical officers employed full time in Government medical services. The Federal Council also resolved to appoint a committee to prepare a log of salaries and conditions of service of Government medical officers for submission to the Branches for consideration. The President, Dr. H. C. Colville and Dr. C. Byrne were appointed members of this committee. The Federal Council also resolved that it would write to the Repatriation Department Medical Officers' Association, offering support in its present application to the Public Service Arbitrator for increase in salaries.

A Film Showing Convulsive Shock Therapy.

At its meeting in August, 1948, the Federal Council considered a letter from the Queensland Branch drawing attention to a film that had been shown in Queensland depicting the administration of convulsive shock therapy to a psychotic patient. The Queensland Branch held that the public showing of such a film was not in the public interest. It was thought that the film would frighten people and would make many persons unwilling to undergo this form of therapy when it was advisable for them to have it. The Federal Council decided that the matter should be taken up with the Commonwealth Film Censor. The General Secretary reported that he had written to the Commonwealth Film Censor and had received a sympathetic reply stating that it was regretted that pending operation of uniform film censorship legislation at present being enacted by the various State Parliaments it was not possible to order withdrawal of the film, but the distributing company concerned would be advised of the Council's views. The Federal Council decided to thank the Commonwealth Film Censor for his communication.

Proprietary Medicines Investigation Committee.

The General Secretary reported that in the absence of Dr. A. J. Collins overseas, Dr. H. R. R. Grieve had acted as the Federal Council's representative on the Proprietary Medicines Investigation Committee.

Taxation on Post-Graduate Expenses.

At previous meetings the Federal Council had dealt with taxation on the expenses of medical practitioners engaged in post-graduate studies. The present position was that if a practitioner undertook a refresher course the Commissioner for Taxation would allow reasonable expenses as taxation rebates on the ground that the expenditure was made in order to maintain efficiency. If, however, after a course of post-graduate study a practitioner obtained a senior degree or diploma, no taxation concessions were allowed, since it was held that he had gained a capital asset. The General Secretary reported that he had written to the Prime Minister in the matter and had pointed out that there was no more effective way for a practitioner to maintain his efficiency than by studying for a higher degree or diploma. A reply from the Prime Minister was still being awaited.

Assistance to Students by the Universities Commission.

The General Secretary reported that he had received a letter from the South Australian Branch drawing attention to a clause in the form of application which students were required to sign before financial assistance was granted to them by the Universities Commission. By signing this clause they promised to undertake national service if required for not more than three years immediately following graduation. The South Australian Branch asked for clarification of the position in regard to a medical graduate who desired to serve a period of one year as a resident medical officer. The General Secretary said that he had discussed the matter with the Secretary of the Universities Commission and had written to the South Australian Branch explaining that a year's service as resident medical officer by a recent graduate was part of his education. According to the terms of some medical acts a year's service as resident medical officer was obligatory before his degree could be conferred upon him. No obstacle would be placed in the way of a student who wished to serve as resident medical officer for one year. The General Secretary's action was approved.

Repatriation Department.

Medical Benefits for Widows, Widowed Mothers and Orphans of the 1939-1945 War.

A letter was received from the Chairman of the Repatriation Commission stating that, in accordance with clauses 8 and 9 of the agreement, the rates payable to Repatriation local medical officers for the year 1938-1939 would be as follows: metropolitan rate, £1 17s. 3d.; country rate, £2 5s. 10d. The General Secretary stated that this information had been conveyed to the Branches.

Medical Benefits for Widows, Widowed Mothers and Orphans of the 1914-1918 War.

The General Secretary reported that a letter had been received from the Chairman of the Repatriation Commission asking whether widows and dependants of the 1914-1918 war could be placed on the same basis as those of the 1939-1945 war in regard to medical benefits. The matter had been referred to the Branches and all had been in favour of the proposal. The request of the Chairman of the Repatria-

tion Department was therefore approved by the Federal Council.

Fees Payable to Local Medical Officers.

At several of its previous meetings the Federal Council had considered the fees payable to local medical officers of the Repatriation Commission for out-patient treatment. The rates of pay in existence were ten shillings for each of the first two visits, seven shillings and sixpence for each of the next three visits, and five shillings subsequently. The Federal Council wished to have the rate increased to provide for a minimum rate of ten shillings and sixpence per visit or consultation. The General Secretary reported that he had written to the Minister for Repatriation asking for a review of the previous decision. The Federal Council resolved that if the Minister refused any request for a uniform fee of ten shillings and sixpence the Federal Council should press for a 50% increase in the present rates of payment of local medical officers.

Fee for Reports on Ex-Service Personnel.

At several previous meetings the Federal Council considered the inadequate fee of ten shillings which was paid by the Repatriation Commission for reports from medical practitioners on ex-service personnel. The General Secretary reported that he had written to the Commission asking for a review of the decision and that he was awaiting a reply.

Dr. H. W. Horn brought up the question of the completion of Form KK and drew attention to the amount of detail required in the completion of the form. After discussion it was resolved that the fee for completion of this form should be two guineas.

The Treatment of War Widows in Repatriation Hospitals.

At a previous meeting the Federal Council had discussed the treatment of war widows in repatriation hospitals and had asked whether they were entitled to the free choice of doctor and, if not, whether they were treated by members of the visiting medical staff. The Chairman of the Repatriation Commission had replied that war widows admitted to repatriation medical institutions were not entitled to a free choice of doctor and that their treatment was carried out by both full-time and visiting medical officers of the hospitals concerned. At its meeting in August, 1948, the Federal Council had resolved that the Repatriation Commission should be asked to allow war widows to have the free choice of doctor from among members of the visiting staffs of repatriation hospitals. The General Secretary reported that he had received a reply from the Chairman of the Repatriation Commission advising that the Commission was unable to see its way clear to agree to the Council's request. The reply was received.

Fees Paid to Visiting Specialists at Repatriation Hospitals.

At its meeting in August, 1948, the Federal Council considered the fees paid to visiting specialists at repatriation hospitals and came to the conclusion that in those hospitals in which payment was made on a sessional basis the rates should be: up to two hours, four guineas; up to three hours, five guineas. The General Secretary said that this decision had been communicated to the Chairman of the Repatriation Commission, but no reply had been received.

The Federal Council held a short discussion on payment for special types of surgery, such as thoracic surgery. It was pointed out that operations on the thorax and on the brain were time-consuming and that in the opinion of many payment for these procedures on a sessional basis was inequitable. Payment on a fee-for-service basis was thought to be desirable and in fact was being sought by a surgeon in one of the States. No immediate action was decided upon.

Medical Education.

The General Secretary stated that he had received copies of the Parent Body's report on medical education in Great Britain, entitled "The Training of a Doctor". These had been sent to members of the Federal Council.

The Gold Medal of the British Medical Association in Australia.

The General Secretary reported that he had obtained gold medals to replace those of base metal which had been presented to Dr. C. H. Mollison and Dr. A. Graham Butler by the Federal Council. Gold had been unobtainable during the war years. Fortunately Dr. Graham Butler had received his gold medal just before his death. The General Secretary read a letter that he had received from Dr. Butler.

The Federal Council learned with great regret of the recent death of Dr. A. Graham Butler and stood in silence as a tribute to his memory. It also adopted the following resolution:

That the Federal Council records its deepest sympathy with the widow and family of the late Dr. A. Graham Butler, and in doing so, places on record its appreciation of the outstanding services he rendered to the profession and particularly for his monumental history of the Australian Army Medical Corps in the First World War, 1914-1918.

Medical Ethics.

A communication was received from the South Australian Branch containing certain recommendations setting out the confidential nature of reports by medical practitioners. It was explained that the recommendations were the outcome of an incident in South Australia and it was thought that the position should be clearly stated. The Federal Council resolved as follows:

(a) Any report supplied at the request of a patient or his solicitor shall be considered as the exclusive property of the person who made the request, the contents of such report being treated as a professional secret and not being disclosed to any other party.

(b) That in the interests of the patient, where a separate report is required provision should be made for the arrangement of a consultation with the patient's previous medical attendant, but even in these cases such report should be treated as in paragraph (a) and be sent separately.

Department of Post-War Reconstruction: Rehabilitation Case Record.

A request was received from the New South Wales Branch that the fee for completion by a medical officer of Rehabilitation Case Record, Form 3b, should be increased from ten shillings and sixpence to two guineas. The General Secretary said that he had referred the matter to the Branches and that varying replies had been received. Federal Council discussed the matter and decided that a fee of ten shillings and sixpence, in addition to the general practitioner or specialist consultation fee, was adequate.

Superannuation Benefits for Medical Practitioners.

A letter was received from the New South Wales Branch in which it was stated that it was very difficult at the present time for medical practitioners to set aside any sums of money which would permit of their retiring at a reasonable age. It appeared to the New South Wales Branch that the position might be met if medical practitioners provided superannuation benefits for themselves by means of endowment policies. Unfortunately the present *Income Tax Assessment Act* permitted of rebates on life assurance premiums up to only £100. The New South Wales Branch Council thought that this amount would have to be greatly increased to permit of medical practitioners taking out policies sufficiently large to provide a reasonable income. It therefore recommended to the Federal Council that an approach should be made to the Federal Treasurer with a view to the securing of an amendment to the *Income Tax Assessment Act* so as to provide that endowment assurance premiums up to £500 *per annum* should be allowable deductions for income tax purposes. The Federal Council resolved to approach the Commonwealth Treasurer as suggested by the New South Wales Branch.

The Standards Association of Australia.

A request was received from the Standards Association of Australia for comments on draft specifications for compressed gas cylinders. The General Secretary said that he had sent a copy of the letter to the Australian Society of Anaesthetists and had received a reply. During discussion, Dr. F. W. Carter emphasized the importance of the standardization of gas cylinders and mentioned some accidents that had occurred. The Federal Council resolved to forward the letter of the Australian Society of Anaesthetists to the Standards Association of Australia. It also adopted a resolution stating that in its opinion there should be uniform and easily identifiable cylinders for each of the various types of gases used in anaesthesia.

London House.

The General Secretary referred to London House, situated at Guildford Street, London, W.C.1, and said that Brigadier E. C. Pepper, its controller, would visit Australia in June, 1949. The Federal Council resolved that the Branches should

be informed of Brigadier Pepper's visit and should be asked to draw the attention of members to it.

The Fee Payable to Local Commonwealth Medical Officers for Examining Applicants for Invalid Pensions.

A request was received from the Victorian Branch that some action should be taken to increase the fees paid to local Commonwealth medical officers. The Victorian Branch resolution stated that at the present time the sum of ten shillings was paid for the examination of applicants for invalid pensions at the surgery and that the sum of fifteen shillings was paid for an examination away from the surgery, irrespective of distance. It was thought that the fees payable should be exclusive of mileage and that mileage rates should be allowed in addition to the examination fee. The Federal Council agreed to take the steps asked for by the Victorian Branch and resolved that the fees paid for the examination of applicants for invalid pensions and the supplying of reports should be one guinea if the examination was made in the surgery and twenty-five shillings *plus* mileage one way beyond two miles if the examination was made away from the surgery.

Votes of Thanks.

The Federal Council passed a vote of thanks to the President, Dr. Victor Hurley, for presiding. It also passed votes of thanks to the Victorian Branch Council for its hospitality and for the use of its Branch offices, and to Dr. Victor Hurley, Dr. H. C. Colville and Dr. Charles Byrne for their hospitality.

Date and Place of Next Meeting.

The determination of the date and place of the next meeting was left in the hands of the President.

SCIENTIFIC.

A MEETING of the New South Wales Branch of the British Medical Association was held on December 2, 1948, at the Saint George Hospital, Kogarah. The meeting took the form of a series of clinical demonstrations by the members of the honorary medical staff of the hospital. Part of this report appeared in the issues of April 2 and April 9, 1949.

Orthopaedic Conditions.

A series of patients of Dr. C. HUDSON were presented by Dr. E. NUFFIELD to illustrate various orthopaedic conditions.

Charcot's Joint of the Left Knee.

The first patient was a woman, aged forty-two years, with Charcot's joint of the left knee. The joint had been "giving way" for the past twelve months, but had caused no pain. On examination the joint was found to be very unstable, and crepitus was present. The Wassermann test produced a strongly positive reaction. The condition was differentiated from osteoarthritis by the increased mobility, the painlessness and the positive serological findings. It was treated by means of a knee cage.

Congenital Pseudarthrosis.

The second patient was a woman, aged fifty-four years, with congenital pseudarthrosis of the left tibia, which she had had for as long as she could remember. She had undergone an operation fifty years before, when apparently an attempt was made at "wiring". At the time of the meeting she was being treated by means of a double onlay graft screwed together. The ankle joint was completely disorganized, but despite a pronounced limp the patient walked painlessly.

Bilateral Perthes's Disease.

The third patient presented was a boy, aged twelve years, suffering from bilateral Perthes's disease. It was active in the left hip, but the right hip had healed. An X-ray film was shown to demonstrate the end result of the untreated condition.

Multiple Urinary Calculi.

Dr. R. INNES CAMPBELL presented a male patient, aged thirty-four years, who, when admitted to hospital, had complained of attacks of pain in both renal angles intermittently for about ten years. Occasional small stones had been passed *per urethram*. Considerable impairment of renal

function was demonstrated by the indigo-carmin and urea clearance tests, and by blood urea estimation. X-ray examination revealed a large staghorn calculus in the left kidney, and calculi in the left ureter and in the region of the right renal pelvis. These were removed at operation. Pathological examination of urine taken from the ureters revealed numerous pus and red blood cells, as well as coliform bacilli, of which a culture was made. The patient had remained in good health since operation, and was free of pain. The right kidney was apparently functioning normally, but the function of the left kidney was impaired, apparently because of the prolonged obstruction by the calculus in the left ureter and the direct damage to the kidney caused by the staghorn calculus.

Cæsarean Section for Complicated Labour.

Dr. N. RAU discussed the case of a married woman, aged thirty-three years, who had been admitted to hospital for trial labour at full term with first stage labour pains. She had had one previous pregnancy and had been delivered of a full-term infant by Cæsarean section, because of disproportion and toxæmia of pregnancy. Ten hours after her admission to hospital for her second confinement, the fetal head had advanced only a little in spite of satisfactory first stage pains. No reason could be discovered for the delay. Fourteen hours later, in spite of satisfactory pains and the administration of sedatives, no progress had taken place, and the mother was tired. A lower segment Cæsarean section was performed. The lower uterine segment was greatly thinned, the fetal parts being clearly visible through it. The umbilical cord was twisted three times tightly around the fetus's neck, and that was considered to be the cause of the delay in the progress of labour. A living male infant was delivered, and convalescence was uneventful.

Ruptured Uterus.

Dr. Rau next presented a married woman, aged twenty-six years, who had been delivered of a stillborn infant at the Royal Hospital for Women twelve months previously. It was said by the patient to have been a breech delivery. When admitted to the Saint George Hospital, the patient was pregnant, her last menstrual period having occurred nine months before. She had been well until about twenty-two hours before her admission to hospital, when she suddenly developed lower abdominal pains. The pain was accentuated by vomiting and relieved by lying down, but was continuous, and after a while was felt about the site of the fundus. There was no history of trauma or of vaginal hemorrhage. On her admission to hospital a state of shock was evident, and as this increased, the pain continued and the pulse rate rose; laparotomy was performed. A perforation of the fundus of the uterus about the size of a two shilling piece was discovered. The membranes were bulging through, and the peritoneal cavity was full of fluid and clotted blood. Hysterotomy was performed by enlargement of the fundal perforation, and the amniotic sac complete with a five-month fetus was removed. Convalescence was uneventful, and the patient was discharged from hospital, quite well, seventeen days after the operation. During her convalescence records of her previous confinement at the Royal Hospital for Women became available, and revealed that there had been primary uterine inertia, the first stage of labour lasting for fifty-two hours. Instrumental delivery of a macerated infant had been followed by unsuccessful attempts at expulsion of the placenta, ending in manual removal of a partly adherent placenta. The patient had collapsed during the operation, and resuscitation measures had been necessary. The convalescence had been febrile and prolonged, the patient being in hospital for forty-six days.

Accidental Hæmorrhage.

Dr. Rau's last patient was a woman, aged thirty-five years, who had been admitted to hospital at seven and a half months in her sixth pregnancy. Her previous confinements had all been normal and at full term. When admitted to hospital she complained of lower abdominal "cramps" present since the previous day. She had noticed that her uterus had suddenly enlarged. A few clots were passed *per vaginam* just before her admission to hospital. The patient was "waxy" pale and in great pain. Slight vaginal hemorrhage was present, and the uterus was tense and very tender to pressure. Lower segment Cæsarean section was performed, and a large retroplacental hemorrhage, almost completely separating the placenta, was discovered. A stillborn infant was delivered. Convalescence was uneventful.

Dr. A. M. MACINTOSH presented a married woman, aged twenty-one years, who had been admitted to hospital com-

plaining of hæmorrhage *per vaginam* of five days' duration, and severe pain in the back and left iliac fossa, which had been present all day and was becoming more severe and generalized throughout the abdomen. On examination the patient appeared well, but was obviously in very severe pain. Her last menstrual period had occurred five months previously. An attack of vaginal hæmorrhage, lasting for fifteen days intermittently, had occurred four weeks before her admission to hospital. It was unaccompanied by any clots, and had ceased after the injection of "Lipolutin". She had undergone two operations for appendicitis six years previously. The lower part of the abdomen was found to be occupied by a tumour, regular, rounded, hard, tense and very tender, corresponding in size, position and shape to a twenty-weeks pregnant uterus. The abdomen above the tumour was tender but soft. It was observed that the tumour became harder when regular spasms of more severe pain occurred. Vaginal examination revealed a tense, cystic, very tender swelling filling all fornices. After consultation with Dr. K. S. Richardson, the diagnosis of concealed accidental hæmorrhage was made on the following grounds: (i) some hæmorrhage had occurred *per vaginam*; (ii) the only abdominal tumour which could be felt appeared to be a very tender, tense uterus, apparently contracting; (iii) the cervix uteri formed the centre of a tense, tender, cystic mass tightly filling and pushing into all fornices. In view of these findings the uterus was considered to be the focus of the trouble, and because of the contractions it was concluded, and hoped, that labour had commenced. It was decided to relieve the pain and to hope that labour would continue and lead to spontaneous delivery and clarification of the diagnosis. Injections of morphine were given as necessary, a tight abdominal binder was applied and the membranes were ruptured when the cervix was dilated sufficiently to admit two fingers. Four hours later the fetus was expelled, and placenta and clot were later removed with forceps. Blood transfusion and a course of penicillin were commenced. Convalescence was uneventful.

Dr. H. A. ANNETTS presented a married woman, aged thirty years, who had been admitted to hospital during her third pregnancy with a blood pressure of 160 millimetres of mercury (systolic) and 110 millimetres (diastolic). There were no other signs of abnormality, and after rest in bed for fourteen days her blood pressure had fallen to 140 millimetres of mercury (systolic) and 90 millimetres (diastolic), and her condition was satisfactory. Early next morning the patient was stated to have called out, and was found on the floor. She appeared to be mentally confused, although recovering, but she passed urine and fæces while on the floor. She denied any history of epilepsy or convulsions. She was pale, with a systolic blood pressure of 50 millimetres of mercury and a pulse rate of 72 per minute. The uterus was somewhat tense, and no fetal heart sounds could be heard. An hour later she began to lose *per vaginam* what appeared to be blood-stained liquor amnii. Half an hour later the fundus of the uterus was one inch lower, faint uterine contractions were detected, and the patient appeared to be in the first stage of labour. Her general condition was improved. A blood transfusion was ordered, and pitocin was given. Her general condition continued to improve. Labour proceeded, and at 1.30 p.m. a stillborn infant was delivered. The placenta was spontaneously delivered, and a large retroplacental clot was found. Penicillin was administered, and convalescence was uneventful.

Dr. N. SAXBY presented a married woman, aged thirty-six years, who had been admitted to hospital in December, 1947, in about the sixth month of her fourth pregnancy. She had had one child in 1944, having suffered from hypertension early in the pregnancy, and two subsequent miscarriages, apparently associated with *hyperemesis gravidarum*. The patient was admitted to hospital late at night, with a history of having become giddy and fainted during the morning of the same day. She had been examined at the time by her private doctor, who had heard fetal heart sounds. In the afternoon she had felt very ill and experienced a good deal of pain, followed later in the day by vomiting. Vaginal hæmorrhage was occurring at 10 p.m. She was admitted to hospital in a state of severe shock. A blood transfusion was commenced, with improvement in her general condition, and hysterotomy was performed. Severe hæmorrhage was found at the placental site and the uterus was full of blood, with invasion of the muscle and blood under the peritoneal surface. A dead six-months fetus was removed. Convalescence was uneventful.

Renal Calculus Complicating Pregnancy.

Dr. Saxby's other patient was a married woman, aged thirty years, who was between four and five months pregnant. Her only previous pregnancy had been terminated

by a Cæsarean section for disproportion after a trial of labour. X-ray examination of the pelvis in September, 1948, had revealed the unsuspected presence of a large, branching calculus in the right kidney. Further investigation revealed impairment of function of the right kidney, with pronounced hydronephrosis. It had been decided to watch the patient carefully during her pregnancy, and to remove the calculus later.

Post-Graduate Work.

THE POST-GRADUATE COMMITTEE IN MEDICINE IN THE UNIVERSITY OF SYDNEY.

GENERAL REVISION COURSE.

THE Post-Graduate Committee in Medicine in the University of Sydney announces that the annual general revision course will be held in Sydney for two weeks beginning on May 23, 1949, under the supervision of Dr. Frank L. Ritchie. Fees for attendance will be as follows: Full course, £5 5s.; mornings or afternoons only, £3 3s.; and one week only, £3 3s. Early application, enclosing remittance, should be made to the Course Secretary, The Post-Graduate Committee in Medicine, 131 Macquarie Street, Sydney. Telephones: BU 5238, BW 7483. Telegraphic address: "Postgrad Sydney".

Owing to the number of candidates attending the clinical demonstrations on each Friday afternoon, the class will be divided into two groups.

Programme.

First Week.

Monday, May 23, at the Stawell Hall, 145 Macquarie Street. The course will be opened by the chairman, Colonel A. M. McIntosh. The subjects for discussion will be "Cardiology in General Practice", "B.C.G. Vaccination against Tuberculosis". In the afternoon a seminar on antibiotics will be held under the chairmanship of Professor H. K. Ward.

Tuesday, May 24, at the Stawell Hall, 145 Macquarie Street, Sydney. The subjects will include "Diseases Affecting the Blood", "Scope and Indications for Newer Vascular Surgery", "The Treatment of Burns". A seminar on traumatic surgery will be held in the afternoon.

Wednesday, May 25, at the Robert H. Todd Assembly Hall, 135 Macquarie Street. The subjects will include "Allergic Diseases, with Special Reference to the Treatment of Hay Fever", "The Place of Isotopes in Modern Medicine", "Common Eye Disorders in General Practice", "The Diagnosis and Treatment of Diseases of the Stomach and Duodenum". A seminar on the place of surgery in the treatment of peptic ulcer will be held in the afternoon (chairman, Professor H. R. Dew).

Thursday, May 26, at the Robert H. Todd Assembly Hall, 135 Macquarie Street. The subjects will include: "Management of Diabetic Pre-Coma and Coma", "The Pneumonias", "Recent Advances in Endocrinology", "The Management of Thyrotoxicosis". In the afternoon a clinico-pathological conference will be held at the Sydney Hospital.

Friday, May 27, at the Robert H. Todd Assembly Hall, 135 Macquarie Street. The subjects will include: "The Prevention of Emergencies and Shock", "Emergencies Arising in Toxæmias of Pregnancy", "Hæmorrhages", "Ruptured Uterus", "Fœtal Distress". Clinical demonstrations will be held in the afternoon.

Saturday, May 28, at Broughton Hall Psychiatric Clinic, Leichhardt. A demonstration of cases will be held.

Second Week.

Monday, May 30, at the Stawell Hall, 145 Macquarie Street. The subjects will include: "Orthopaedic Problems as they Affect the General Practitioner", "Old and New Drugs in the Control of Epilepsy", "Recent Advances in Anti-Coagulant Therapy in Medicine and in Surgery", "Treatment of Varicose Veins and Hæmorrhoids", "Ear, Nose and Throat in General Practice".

Tuesday, May 31, at the Stawell Hall, 145 Macquarie Street. The subjects will include: "The Modern Management of Congestive Heart Failure", "Sciatica", "Commoner Skin Conditions and their Treatment".

Wednesday, June 1, at the Stawell Hall, 145 Macquarie Street. The subjects will include: "Gynaecology in General

Practice", "The Management of the Menorrhagias", "Sterility: Problems in Diagnosis", "The Management of the Menopause". A seminar will be held on presenting factors in the reduction of neo-natal mortality. "Medicine Abroad" will be discussed in the evening.

Thursday, June 2, at the Royal Alexandra Hospital for Children, Camperdown. The subjects will include: "Appropriate Ages for Operations on Children", "The Importance of Fluid Balance in Pediatrics", "Control of Infectious Diseases and Artificial Immunization". A registrar demonstration will be held.

In the afternoon at the Royal Prince Alfred Hospital, Camperdown, a pathology demonstration and a dermatology demonstration will be held. A clinico-pathological conference will also be held.

Friday, June 3, at the Stawell Hall, 145 Macquarie Street. The subjects will include: "Psychotherapy of Functional Disorders", "Emergency Eye Conditions", "Choice of Anæsthesia in General Practice". Clinical demonstrations will be held in the afternoon.

Saturday, June 4, at the Stawell Hall, 145 Macquarie Street. A "quiz forum" will be held.

Written questions will be submitted during the two weeks and answered by a selected forum on the last day of the course if there are sufficient questions to warrant this session.

ROYAL PRINCE ALFRED HOSPITAL.

A POST-GRADUATE AFTERNOON has been arranged weekly at the Royal Prince Alfred Hospital, consisting of a seminar, a post-mortem demonstration and grand rounds. The programme is held on Friday afternoons and commences at 1 p.m. The following are the proposed seminars for April, 1949:

- April 1: Clinico-pathological conference.
- April 8: Thoracic section, "Bronchial Adenoma".
- April 22: Cardio-vascular section, "The Value of X Rays in the Diagnosis of Cardiac Enlargement".
- April 29: Endocrinology and metabolism section, "Myxoedema".
- May 6: Hæmatology section, "Anæmia and Pregnancy".

THE MELBOURNE PERMANENT POST-GRADUATE COMMITTEE.

PROGRAMME FOR MAY.

Classes for Higher Degrees and Diplomas.

Classes for candidates for Part I M.D., M.S., D.O., D.L.O., D.G.O., D.D.R. and D.A. will be continued at the University during May.

M.D. Part II and M.R.A.C.P.: Clinical Demonstrations.

Pædiatric Disorders.—The classes in pædiatric disorders which commenced in April will be continued in May at the Children's Hospital.

Endocrinology.—The following demonstrations in endocrinology at various hospitals are under the direction of Dr. Keith D. Fairley. May 17: "Disorders of the Pituitary Gland", Dr. John Bolton; May 19: "Disorders of the Parathyroid Glands", Dr. R. M. Biggins; May 24: "Disorders of the Thyroid Gland", Dr. K. D. Fairley; May 26: "Disorders of the Adrenal Glands", Dr. R. Andrew; May 31: "The Endocrinology of the Female", Professor J. W. Johnstone; June 2: "Endocrine Aspects of Hyperglycæmia and Hypoglycæmia", Dr. Ewen Downie. The fee for this course is £3 3s.

Enrolments.

Enrolments for any of the above courses should be made with the Secretary of the Committee, 426 Albert Street, East Melbourne (JM 1547), two weeks before commencement.

D.G.O. Part II and M.R.C.O.G.

The Victorian State Committee of the Royal College of Obstetricians and Gynaecologists advise that the course for M.R.C.O.G. will not be held until early 1950, in accordance with a postponement of the examination date. Should there be a sufficient demand for classes for D.G.O. Part II they will conduct a course for this examination commencing

about July next, and those interested are asked to notify the Post-Graduate Committee or Dr. W. J. Rawlings, 12 Collins Street, Melbourne (JM 1375), as soon as possible.

Demonstration at Flinders Naval Depot.

On May 11, 1949, at 2.30 p.m., Dr. R. Kaye Scott will discuss "Indications for Radiation in General Practice" at Flinders Naval Depot, by arrangement with the Royal Australian Navy.

Clinic at Eye and Ear Hospital.

The Victorian Eye and Ear Hospital will hold an afternoon meeting on Tuesday, May 3, 1949, at 4.30 p.m., when Dr. D. O'Brien will conduct an ear, nose and throat clinic.

Medical Practice.

POLICE OFFENCES (AMENDMENT) ACT.

ADVICE has been received from the Under Secretary to the New South Wales Chief Secretary's Department that the following amendments relating to prescriptions have been made to the Drug Regulations under the *Police Offences (Amendment) Act, 1908*, as amended.

The Regulations under the Police Offences (Amendment) Act, 1908, as amended by subsequent Acts, are amended:

- (a) by *omitting* from paragraph (4) of Regulation 1 the definition of "prescription";
- (b) by *omitting* from paragraph (2) of Regulation 8 the word "given" and by *inserting* in lieu thereof the words "issued in accordance with these Regulations";
- (c) by *inserting* at the end of paragraph (1) of Regulation 17 the words "containing any drug";
- (d) by *inserting* in paragraph (2) of Regulation 17 after the word "prescription" where firstly occurring the words "containing any drug".

The relevant regulations as they now stand are as follows.

Regulation 8 (2): A person to whom a prescription for a drug has been issued in accordance with these Regulations is hereby authorized to procure and have possession of the drug to the extent specified in the prescription.

Regulation 17 (1): No person other than a medical practitioner authorized under Regulation 8 to procure and be in possession of any drug or registered veterinary surgeon similarly authorized shall issue a prescription containing any drug.

Regulation 17 (2): Where a medical practitioner or a registered veterinary surgeon issues a prescription containing any drug he shall comply with the following conditions

Obituary.

CRAWFORD HENRY MOLLISON.

WE regret to announce the death of Dr. Crawford Henry Mollison, which occurred on April 6, 1949, at Melbourne.

Nominations and Elections.

THE undermentioned have applied for election as members of the New South Wales Branch of the British Medical Association:

Roberts, Gwyneth Emilie, M.B., B.S., 1948 (Univ. Sydney), Rachel Forster Hospital, Pitt Street, Redfern.
Trenerry, Edwin John, M.B., B.S., 1948 (Univ. Sydney), Sydney Hospital, Macquarie Street, Sydney.

THE undermentioned have applied for election as members of the Tasmanian Branch of the British Medical Association:

Correy, Joseph Frederick, M.B., B.S., 1947 (Univ. Sydney), Royal Hobart Hospital, Hobart.
Sleeman, William John, M.B., B.S., 1947 (Univ. Adelaide), Royal Hobart Hospital, Hobart.

Diary for the Month.

- APRIL 18.—Victorian Branch, B.M.A.: Finance, House and Library Subcommittee.
APRIL 19.—New South Wales Branch, B.M.A.: Medical Politics Committee.
APRIL 20.—Western Australian Branch, B.M.A.: General Meeting.
APRIL 21.—New South Wales Branch, B.M.A.: Clinical Meeting.
APRIL 21.—Victorian Branch, B.M.A.: Executive Meeting.
APRIL 22.—Queensland Branch, B.M.A.: Council Meeting.
APRIL 26.—New South Wales Branch, B.M.A.: Ethics Committee.
APRIL 27.—Victorian Branch, B.M.A.: Council Meeting.
APRIL 28.—New South Wales Branch, B.M.A.: Branch Meeting.
APRIL 28.—South Australian Branch, B.M.A.: Listerian Oration.
MAY 3.—New South Wales Branch, B.M.A.: Organization and Science Committee.
MAY 4.—Victorian Branch, B.M.A.: Branch Meeting.
MAY 4.—Western Australian Branch, B.M.A.: Council Meeting.
MAY 5.—South Australian Branch, B.M.A.: Council Meeting.
MAY 6.—Queensland Branch, B.M.A.: Branch Meeting.
MAY 10.—New South Wales Branch, B.M.A.: Executive and Finance Committee.

Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

New South Wales Branch (Honorary Secretary, 135 Macquarie Street, Sydney): Ashfield and District United Friendly Societies' Dispensary; Balmain United Friendly Societies' Dispensary; Leichhardt and Petersham United Friendly Societies' Dispensary; Manchester Unity Medical and Dispensing Institute, Oxford Street, Sydney; North Sydney Friendly Societies' Dispensary Limited; People's Prudential Assurance Company Limited; Phoenix Mutual Provident Society.

Victorian Branch (Honorary Secretary, Medical Society Hall, East Melbourne): Associated Medical Services Limited; all Institutes or Medical Dispensaries; Australian Prudential Association, Proprietary, Limited; Federated Mutual Medical Benefit Society; Mutual National Provident Club; National Provident Association; Hospital or other appointments outside Victoria.

Queensland Branch (Honorary Secretary, B.M.A. House, 225 Wickham Terrace, Brisbane, B.17): Brisbane Associated Friendly Societies' Medical Institute; Bundaberg Medical Institute. Members accepting LODGE appointments and those desiring to accept appointments to any COUNTRY HOSPITAL or position outside Australia are advised, in their own interests, to submit a copy of their Agreement to the Council before signing.

South Australian Branch (Honorary Secretary, 178 North Terrace, Adelaide): All Lodge appointments in South Australia; all Contract Practice appointments in South Australia.

Western Australian Branch (Honorary Secretary, 205 Saint George's Terrace, Perth): Wiluna Hospital; all Contract Practice appointments in Western Australia. All government appointments with the exception of those of the Department of Public Health.

Editorial Notices.

MANUSCRIPTS forwarded to the office of this journal cannot under any circumstances be returned. Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary be stated.

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